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WITHHOLDING FOOD AND WATER FROM VEGETATIVE PATIENTS IN
MILITARY HOSPITALS: CONSTITUTIONAL AND PRACTICAL CONCERNS

A Thesis

Presented to

The Judge Advocate General's School, United States Army

The opinions and conclusions expressed herein are those of the author and do not necessarily represent the views of either The Judge Advocate General's School, The United States Army, or any other governmental agency.

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38th JUDGE ADVOCATE OFFICER GRADUATE COURSE

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TABLE OF CONTENTS

I.	SOURCES	1
A.	The Due Process Clauses	1
B.	The Constitutional "Right of Privacy"	2
1.	"Discovered" by the Supreme Court	2
2.	Followed by the States	5
C.	Bodily Integrity and the Common Law	6
D.	States: The Right to Consent and the Right to Refuse Treatment	7
E.	Federal Concurrence	7
F.	Self-Determination	8
II.	PROTECTING the RIGHT	9
A.	Fundamental Rights	9
B.	Fundamental Protection for Families	10
C.	"Rooting" a Fundamental Right	10
D.	States, Privacy and Withdrawing Food and Water	12
III.	DEFINITIONS	14
A.	What is "Treatment"?	14
B.	The Persistent Vegetative State	17
C.	Irreversibility and Terminal Illness	18
IV.	REGULATING a FUNDAMENTAL RIGHT	19
A.	Fundamental Rights/Due Process Clause	19
B.	Four Traditional Interests: Are They "Compelling"?	20
1.	Preservation of Life	21
2.	Prevention of Homicide and Suicide	22
3.	Protection of Third Parties	24
4.	Ethical Integrity of Medical Profession	24
C.	Rights for Competents and Incompetents	26
V.	EVIDENTIARY TESTS and STANDARDS	28
A.	Substituted Judgment Test	28

B.	"Objective" or "Best Interests" Test	31
1.	No Consciousness, No Pleasure	32
2.	Mere Maintenance	33
3.	Diminished Dignity	34
4.	Life <u>Qua</u> Life has no Value	34
5.	Invasiveness	35
6.	Others are Burdened	36
C.	Extraordinary and Ordinary Care	37
VI.	LIMITATIONS: The Tests Converge	38
A.	The Tests are Legally Indistinct	38
B.	An Alternative: Family as Decisionmaker	43
C.	Selecting an Evidentiary Standard	44
VII.	THE U.S. MILITARY'S POLICIES	47
A.	No Consensus	47
B.	Army Permits Withdrawing Food and Water	47
C.	Mixed Legal Standards, Ambiguities	48
D.	Ethics Panels	49
VIII.	THERE is NO CONSTITUTIONAL RIGHT to WITHDRAW FOOD and WATER	50
IX.	CURBING the RIGHT of PRIVACY: RETURNING the DECISION to the STATES (and to the MILITARY)	54
X.	"QUALITY OF LIFE," the SLIPPERY SLOPE and EUTHANASIA	57
A.	Rights Beget More Rights	57
B.	Finite Medical Resources	58
C.	Reconsider Value of Life	59
D.	The Case for Humane Lethal Injections	61
E.	Duty to Die; Formulas for Evaluating Life, Redefining Death	62
F.	Harvesting Anencephalics: Redefining Death and its Implications for PVS Patients	63

XI.	UNIQUE PROBLEMS for the MILITARY	66
A.	Population, Mission	66
B.	Fast-Changing Area, Remote Stationing	67
C.	The Services Diverge	68
D.	Conscience Exception	70
XII.	SOLUTION	71
A.	Require Provision of Food and Water	71
B.	Otherwise, Tighten the Regulation	73
1.	Presume in Favor of Care	73
2.	Decisionmaking Hierarchy	74
3.	Informed Consent	74
4.	Define "Terminal"	74
5.	Conscience Exception	75
6.	Ethics Panels	75
C.	The Regulation Makes a Statement	77

WITHDRAWING FOOD AND WATER FROM VEGETATIVE PATIENTS IN
MILITARY HOSPITALS: CONSTITUTIONAL AND PRACTICAL CONCERNS

by CPT Lawrence J. Morris

ABSTRACT: This thesis examines the theories behind the growing movement that permits the withholding or withdrawal of food and water from vegetative or terminally ill patients. It finds that this practice, permitted in the U.S. Army, is based primarily on the constitutional "right of privacy." The theories on which it is based are not constitutionally defensible, and the various tests that federal and state courts have devised to carry it out are flawed and subject to manipulation. The thesis concludes that the Army should rescind its regulation permitting the practice, but that if it does not do so, it should implement major changes that safeguard vegetative patients in military hospitals.

The United States Army permits withholding or withdrawing of nutrition and hydration from certain patients in its hospitals. Many states, by statute or judicial fiat, also permit the practice. This paper will address whether there is a constitutional right to withhold or withdraw nutrition and hydration from persistently vegetative patients and if so, how to better implement the right in the military.

Much of the analysis in this area is grouped under the rubric of the "right to die." Despite the limitations of such shorthand, it effectively communicates the core question: under what circumstances may the government interpose itself in keeping someone alive or in regulating the steps that must be taken before a patient is permitted to expire. (While this paper addresses withholding as well as withdrawing food and water, the text normally will use the term withdrawing, to avoid cumbersome construction and because it is the withdrawing after insertion of feeding tubes, as opposed to the decision not to initiate treatment, that prompts most litigation.)

I. SOURCES

Courts and commentators most often find the right to die grounded in the "liberty" interest protected by the Due Process Clauses of the fifth and fourteenth amendments, and the broad constitutional "right of privacy."

A. The Due Process Clauses

Both Due Process Clauses forbid taking "life, liberty, or property, without due process of law."¹ Both amendments potentially apply to military hospitals. The fifth amendment applies against the federal government, and therefore the military, and the fourteenth amendment applies against the states. The fourteenth amendment applies against the military

to the extent that the military must follow state law in its medical facilities. Though some hospitals may comply with some state licensing requirements and other ministerial regulations, those governing the delivery of medical care, especially withdrawing medical care, do not appear to apply.²

Even the most conservative jurists acknowledge that the Due Process Clause has come to mean more than the words plain from the text. Justice Scalia observed in 1989: "It is an established part of our constitutional jurisprudence that the term 'liberty' in the Due Process Clause extends beyond freedom from physical restraint."³ Courts have expanded this 'liberty' to embrace a right of autonomy in medical decisions. It is difficult to separate this concept from the broader and more broadly-based "right of privacy," as the fourth circuit recently explained:

The right to be free of unwanted physical invasions has been recognized as an integral part of the individual's constitutional freedoms, whether termed a liberty interest protected by the Due Process Clause or an aspect of the right to privacy contained in the notions of personal freedom which underwrote the Bill of Rights.⁴

B. The Constitutional "Right of Privacy"

1. "Discovered" by the Supreme Court

While the word "privacy" appears nowhere in the text of the Constitution, many critics, philosophers and judges assert that privacy undergirds several constitutional rights, especially those guaranteed by the first, fourth, fifth and fourteenth amendments. Early mentions of the right of privacy usually appear in dissent or dicta. Louis Brandeis, later to be a Supreme Court justice, first advanced the concept in his frequently-cited Harvard Law Review article in 1890.⁵ He quoted and further advanced his own concept from the bench a

generation later: "[T]he right to be let alone" is "the most comprehensive of rights and the right most valued by civilized men."⁶

The Supreme Court greatly expanded and enshrined the right of privacy at the zenith of the Warren Court. In Griswold v. Connecticut,⁷ the Court held unconstitutional a Connecticut statute regulating the sale of contraceptives to married couples. Justice Douglas' majority opinion was the first explicitly to address privacy rights found nowhere specifically in the Constitution but in the "shadows" (penumbras) or underpinnings of the Bill of Rights and other specific provisions of the Constitution. Griswold, with a stop for reinforcement at Eisenstadt v. Baird,⁸ provided the basis for the landmark abortion decision eight years later, and numerous other privacy-based challenges since.⁹

In Griswold, Justice Douglas said the "specific guarantees in the Bill of Rights have penumbras, formed by emanations from those guarantees that help give them life and substance."¹⁰ He said that various constitutional rights -- such as free association, and the prohibition against involuntary quartering of soldiers -- as well as the strictures of the fourth and fifth amendments "create zones of privacy" from which similar privacy-based rights can be derived.¹¹

While reinforcing Justice Douglas' description of the right of privacy, Justice Goldberg, concurring in Griswold, acknowledged "that no particular provision of the Constitution explicitly forbids the State from" regulating contraception.¹² The Griswold majority took a popular stand in favor of government's "not invading the bedroom,"¹³ but grasped for extra-constitutional (by any account, extra-textual) grounds on which to base its holding. This left a door well open for the Court to create a constitutional right to abortion. Midwife to the Roe decision, though, was Eisenstadt v. Baird, in which the Court built on Griswold, citing it as the central basis for its decision to hold unconstitutional a Massachusetts law that limited distribution of non-prescription

contraceptives to unmarried persons. Justice Brennan, writing for the unanimous Court, said, "If the right of privacy means anything, it is the right of the individual...to be free from unwarranted governmental intrusion into...the decision whether to bear or beget a child."¹⁴ Brennan broadened Griswold. Neither had anything to do with a decision whether "to bear" a child, but this language provided a comfortable analytical bridge to the virtual elimination of abortion restrictions in the following term.

Roe v. Wade,¹⁵ is steeped heavily in the penumbral, implied right-to-privacy analysis pioneered in Griswold and Baird. Its progeny make clear that placing a right in this sphere makes it essentially untouchable.¹⁶ While also acknowledging that he was exceeding the text of the Constitution, Justice Blackmun, writing for the majority, posited that "a right of personal privacy, or a guarantee of certain areas or zones of privacy, does exist under the Constitution."¹⁷ He relied on Eisenstadt for the proposition that the "Fourteenth Amendment's concept of personal liberty...is broad enough to encompass a woman's decision whether or not to terminate her pregnancy."¹⁸

By finding that "the right of personal privacy includes the abortion decision,"¹⁹ the Court elevated abortion to a fundamental right. This meant it received the highest level of constitutional protection and that proof of a "compelling state interest" was required before any governmental entity could regulate that right.²⁰ Much of Justice Rehnquist's dissent criticized the majority's transforming the standard of review for social legislation from a "rational relationship to a valid state objective" to a compelling interest.²¹ Justice Rehnquist predicted that "adoption of the compelling state interest standard will inevitably require this Court to examine the legislative policies and pass on the wisdom of these policies in the very process of deciding whether a particular state interest put forward may or may not be 'compelling.'"²²

This dissent captures why the selection of a standard of review will be so important when the Supreme Court decides

Cruzan v. Harmon in 1990, and determines whether a persistently vegetative individual's election to stop receiving nourishment is protected by the U.S. Constitution.²³ The case involves Nancy Cruzan, a Missouri woman in a persistent vegetative state, whose parents want to stop providing her with food and water through a tube. So long as Missouri only need demonstrate a rational relationship to a valid state objective (e.g. preservation of life, prevention of suicide, protection of third parties, integrity of the medical profession), its requirement that Nancy Cruzan be fed is likely to be upheld. But if the Court views the case as one involving her fundamental right of personal privacy, these state interests are less likely to be found to be compelling. (A projection of the Court's ruling and its impact on the military appears at section IX of this paper.)

Expansion of the right of privacy to strike down the acts of state legislatures continued when the Court stated in Carey v. Population Services Int'l,²⁴ that constitutional protection extended to: "'marriage, procreation, contraception, family relationships, and child rearing and education.'" Certainly, the glib extension to "family relationships" can have an impact in determining who can cut off care for an unconscious, incompetent or terminally ill person.

2. Followed by the States

State courts evaluating patient care have relied on that same constitutional right of privacy and penumbral analysis. The most celebrated case involved the successful efforts of Joseph Quinlan to disconnect his persistently vegetative daughter, Karen, from a respirator. The New Jersey Supreme Court, relying on Eisenstadt, Griswold and Roe, found that Karen's right to privacy included the right to be free from such life-sustaining technology, since she was "irreversibly doomed" anyway.²⁵ The unanimous court said that 21 year-old Karen's father could assert Karen's right of privacy on her

behalf, exercising his "best judgment," which the court also called his "substituted judgment," a standard to come into wider use in cases involving withdrawal of food and water.²⁶ The court said it was certain Joseph Quinlan's decision would be approved by "a society, the majority of whose members would, we think, in similar circumstances, exercise such a choice in the same way."²⁷ Karen was fed by a nasogastric tube, but discontinuing that nourishment was never an issue in the case.²⁸

The Quinlan case set the stage for courts to wrestle with a new controversy in the following decade: under what circumstances food and water could be withheld from terminally ill or vegetative patients. "The right of a patient to refuse medical treatment arises both from the common law and the unwritten and penumbral constitutional right to privacy," wrote the Massachusetts Supreme Judicial Court in a leading case that authorized Patricia Brophy to require her vegetative husband's transfer to a hospital that would honor her direction (offered as the substituted judgment of her husband) that his feeding tube be disconnected or clamped.²⁹

C. Bodily Integrity and the Common Law

While freely acknowledging the extra-textual nature of their constitutional interpretation, advocates of an implied right of privacy, especially in the medical area, claim roots in the common law as well. Many courts quote a 19th century case in which the Supreme Court refused to require a woman plaintiff to submit to a defense-requested physical examination in a tort case: "No right is held more sacred or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law."³⁰

A physician's operating on someone without consent (except in emergency) was a battery at common law and remains so today.³¹ The requirement for consent before an intrusion,

especially a surgical intrusion, into another's body, flows from the principle of a body's inviolability. From it stems the doctrine of informed consent, which restricts physicians from performing surgical procedures without fully disclosing the risks and likely effects. "The root premise" of informed consent "is the concept, fundamental in American jurisprudence, that '(e)very human being of adult years and sound mind has a right to determine what shall be done with his own body....'"³² The cases demonstrate that the purpose of the doctrine is to protect patients' lives and health from choices made exclusively by their physicians. They focus on patient well-being, not an unbridled autonomy to "control their own bodies."³³

D. States: The Right to Consent and the Right to Refuse Treatment

Critical to determining whether there is a "right" to withdraw food and water is the question of under what circumstances the right to refuse treatment is the corollary of the right of informed consent. State courts generally accept the premise that the two rights are intertwined.

The Supreme Court of New Jersey found the right to refuse medical treatment (in this case a competent, terminally ill woman's desire to turn off a respirator) was "primarily protected by the common law."³⁴ More explicitly, in a case involving withdrawing a feeding tube, the Arizona Supreme Court found, "the doctrine of informed consent -- a doctrine borne of the common-law right to be free from nonconsensual physical invasions -- permits an individual to refuse medical treatment."³⁵ It continued: "The right to consent...must necessarily include the right" to refuse treatment.³⁶ The court seemed to tip its ideological hand in its next sentence: "To hold otherwise would...ignore the fact that oftentimes a patient's interests are best served when medical treatment is withheld or withdrawn."³⁷

E. Federal Concurrence

The only reported federal case to consider disconnecting life support in a military hospital (though not involving an active duty patient) made the right more absolute. The District of Columbia District Court held in 1985 that the principle of informed consent, as extended to include the right to refuse treatment should not be qualified by the "nature or purpose of the treatment, or the gravity of the consequences of acceding to or foregoing it."³⁸ The court held unequivocally that "competent adult patients of federal medical facilities with terminal illnesses...have a right to determine for themselves whether to allow their lives to be prolonged by artificial means, including the right to demand the cessation of life support once begun."³⁹ Citing Griswold, Eisenstadt and Roe, the court permitted doctors to disconnect 71-year old Martha Tune's respirator, based on her son's petition.⁴⁰ Because courts generally equate respirators and food and water as life-sustaining treatment that may be withheld,⁴¹ this case states the prevailing federal position.⁴²

F. Self-Determination

Some couch the right to refuse treatment in terms of a patient's right of "self-determination." This, however, is more a rhetorical difference than a separate common-law or constitutional basis for a right to decline medical treatment. In an amicus brief submitted to the Supreme Court in the Cruzan case, the American Academy of Neurology argued: "The recognition of a patient's right to self-determination is central" to correct medical decision making when deciding whether to terminate care.⁴³

In other contexts, courts have focused on this same right of bodily inviolability to bar other intrusions by the state. The Supreme Court has forbidden surgery on a criminal accused

to remove a bullet that could be used as evidence against him,⁴⁴ told California it could not pump a suspect's stomach to retrieve swallowed narcotics,⁴⁵ and invalidated mandatory sterilization for habitual criminals.⁴⁶

II. PROTECTING the RIGHT

Assuming the existence, to some degree, of a right to withdraw nutrition and hydration, still to be resolved is what level of protection this right should receive, and to what extent government should be forbidden from regulating the exercise of the right.

A. Fundamental Rights

When the Supreme Court decrees something a "fundamental right," it grants it the highest constitutional protection, making it susceptible of virtually no limits. Until very recently, the Court steadily expanded the nature and scope of fundamental rights. Justice Harlan's famous dissent in Poe v. Ullman has become the standard for determining how to assess the degree of protection to be afforded a right.⁴⁷ He wrote that a court should determine whether the asserted right fits on a "rational continuum of rights" that normally receive protection.⁴⁸ To receive such heightened protection a right must be "so rooted in the traditions and conscience of our people as to be ranked as fundamental."⁴⁹ In its traditional Due Process analysis, closely tied to and somewhat indistinct from its fundamental rights inquiry, the Court determines whether the asserted right is "deeply rooted in this nation's history and tradition."⁵⁰ In addition, the Court considers whether the asserted right is "implicit in the concept of ordered liberty."⁵¹ Besides considering whether a right is "deeply rooted" and "implicit in our concept of ordered liberty," the Supreme Court will consider whether "under the historic practices of our society" courts have "accorded special

protection" to the asserted right,⁵² -- or "at least exclude...a societal tradition of enacting laws denying that interest."⁵³ The expansion of fundamental rights to embrace abortion and procreation are especially pertinent because they concern personal medical decisions. Given the Court's (until Bowers and Michael H.) tendency to keep expanding the reach of those rights deemed "fundamental" and those grounded in the "right of privacy," such a grouping argues strongly for a right to have one's feeding tubes disconnected at will.

B. Fundamental Protection for Families

Because many arguments for withdrawing food and water are based on an asserted right of family members to implement that right, it is important to consider the protection the Court has extended to family-based decisions.

The Supreme Court traces its recognition of the primacy of the family, and especially of parents, as decision-makers for their children, to the common law.⁵⁴ Justice Stewart observed that the common law "historically...has recognized that natural bonds of affection lead parents to act in the best interests of their children."⁵⁵ The Court expressed this deference still more broadly three years later, finding "that freedom of personal choice in matters of family life is a fundamental liberty interest protected by the Fourteenth Amendment."⁵⁶ The Court also recognized "[t]he fundamental liberty interest of natural parents in the care, custody, and management of their child,"⁵⁷ in Santosky v. Kramer, which required clear and convincing evidence before termination of parental rights.

The Court accords great protection to an individual's right "to make certain unusually important decisions that will affect his own, or his family's destiny."⁵⁸ The Court made clear that this right includes "both substantive and procedural protection,"⁵⁹ a crucial coupling, because withdrawing food and water concerns not only the "right to die," but who will make the decision, subject to what evidentiary standard.

C. "Rooting" a Fundamental Right

In determining whether a right has deep roots or is implicit in our concept of ordered liberty, the Court frequently considers how states have implemented or regulated the right at issue. For example, Justice Blackmun argued in Roe v. Wade that only eight states forbade abortion at the time Texas accepted the common law, and that more restrictive abortion laws were passed around the time of the Civil War, followed about a century later by a "trend toward liberalization."⁶⁰ He concluded that during much of American history "abortion was viewed with less disfavor than under most American statutes currently in effect" and that, therefore, there was no true American tradition of restricting abortion.⁶¹ Justice Blackmun traced the history of abortion all the way to ancient Persia, Greece and Rome in his effort to establish that contemporary abortion laws were a restrictive aberration.⁶²

Justice Rehnquist's rebuttal of Justice Blackmun reveals the temptation of selectivity inherent in such a survey approach to jurisprudence. Justice Rehnquist argued that the right to abortion was "not so rooted" as Justice Blackmun claimed, because most states had restricted abortion for more than a century.⁶³ He noted that 36 of the states restricted abortion in 1868 (when the Texas statute at issue was passed) and that 21 of those 36 laws remained in effect in 1973.⁶⁴ In a similar vein, Justice Stewart said in Griswold that a Gallup poll's report that 46% of Americans supported contraceptive education constituted an insufficient basis for overturning the will of the Connecticut legislature.⁶⁵ He continued: "[T]he scientific miracles of this age have not yet produced a gadget which the Court can use to determine what traditions are rooted in the '[collective] conscience of the people.'"⁶⁶ Justice White used this same concept in 1986 to reject the idea that consensual sodomy merited protection as a fundamental right. He found that all but five of the 37 states made sodomy a

criminal offense when the Georgia statute at issue was passed, that until 1961 all 50 states did so, and that in 1986, 25 states still did so.⁶⁷

D. States, Privacy, and Withdrawing Food and Water

Applying this analysis to cases involving withdrawing food and water yields, on first blush, a nearly unanimous opinion that such a right receives wide recognition and support. Every state, except Missouri, to consider the right to withdraw food and water has permitted it, and most decisions have been based at least in part on right of privacy and the fourteenth amendment's Due Process Clause.⁶⁸ California's highest court, in a case involving a competent paraplegic's attempt to starve herself, said "a desire to terminate one's life is probably the ultimate exercise of one's right to privacy."⁶⁹

Besides the court decisions, numerous polls generally show that large majorities of citizens and physicians favor permitting patients or third parties to withdraw food and water. A 1986 American Medical Association (AMA) poll found that 73% of the physicians surveyed supported "withdrawing life support systems, including food and water, from hopelessly ill or irreversibly comatose patients if they or their family request it."⁷⁰ An ABC poll found that 79% believed that opinions about a patient's "quality of life" should be considered when deciding whether to use life-sustaining technology, and 70% believed that immediate family should make such decisions for incompetent patients.⁷¹ The Colorado Graduate School of Public Affairs found in 1988 that 85% of those surveyed would not want to have their lives maintained with artificial feedings if they became permanently unconscious and could not eat normally.⁷²

In a contrast that shows, if nothing else, that the form of the question is significant, a 1986 survey showed that 73% of physicians said they would continue intravenous fluids for dying terminal patients to prevent dehydration.⁷³ There is,

at minimum, no universal consensus in the profession. Health professionals with experience in nutritional care disagreed with the statement that "starvation is an acceptable way of dying for the terminally ill patient."⁷⁴ In 1984 numerous organizations, including the American Academy of Pediatrics, successfully sought federal legislation that encouraged states to treat withdrawal of nutrition and hydration from handicapped infants, including the "chronically and irreversibly comatose" as a form of actionable child neglect."⁷⁵

Regardless of what the courts hold and the polls show, food and water are commonly, quietly, withheld without judicial sanction. The Minnesota Supreme Court estimated this was happening as frequently as ten times per week in its state hospitals as far back as 1978.⁷⁶ If such findings reflect the support of the medical mainstream, and to the extent that a practice's popularity reflects its "rootedness," such practices lend weight to the argument that the right has roots in our concept of ordered liberty. Leading medical associations, as reflected in polls and policy statements, strongly favor allowing food and water to be withheld or withdrawn from persistently vegetative or terminally ill patients. The AMA resolved in 1989 that "it is not unethical to discontinue all means of life-prolonging medical treatment" (elsewhere it defined artificial nutrition and hydration as medical treatment).⁷⁷ It said this was permissible "[e]ven if death is not imminent but a patient is beyond doubt permanently unconscious."⁷⁸ The American Academy of Neurology (AAN) agreed with the AMA, holding that "the artificial provision of nutrition and hydration may be forgone" from "a patient [who] has been reliably diagnosed as being in a persistent vegetative state."⁷⁹ The Academy believes that "[t]reatments that provide no benefit...may be discontinued" while those that offer "some hope for recovery should be distinguished from treatment (including, at times, food and water) that merely prolongs or suspends the dying process without providing any possible cure."⁸⁰ It is undisputed that giving food and water to a

persistently vegetative patient does not make likely his recovery but merely keeps him alive.

III. DEFINITIONS

Definitions in this area, which can literally mean life or death, take on great significance.

A. What is "Treatment"?

Before deciding whether withdrawing nutrition and hydration qualifies as withdrawing medical treatment, it must be determined whether artificially-delivered food and water are, in fact, "treatment." Even the terms "food and water" arguably lose their neutrality, since they may connote meals or liquids delivered in traditional manners, instead of pureed foods or formulas impersonally delivered through surgically-implanted tubes. On the other hand, "artificial nutrition and hydration" sounds sufficiently technical to be a medical treatment, instead of the delivery of basic sustenance in a manner adapted to the patient's ability to receive it. Vegetative patients receive their nutrients not via a spoon or fork but through a tube inserted through the nose (nasalgastric or N-G tube) or directly into stomach (gastric or G tube). The nasalgastric tube is used unless the patient cannot swallow;⁸¹ gastrostomy tubes, while presenting fewer complications, can obstruct the intestinal tract, erode and pierce the stomach wall or cause leakage of the stomach's contents into the abdomen.⁸²

Some observers view tube feeding as hazardous and intrusive, a viewpoint that has legal implications under formulas that consider intrusiveness and patient dignity when weighing whether to compel treatment.

The naso-gastric tube...may cause vomiting and aspiration of the gastric contents, producing a serious aspiration pneumonia. It may irritate the mucosal surfaces, causing bleeding, sometimes

severe. Many patients need to be restrained forcibly and their hands put into large mittens to prevent them from removing the tube, a thought which all patients with any degree of consciousness seem to have. These restrained patients may develop pneumonia and serious bedsores because of lack of activity and fixed positions.⁸³

Others, however, argue that such nourishment "can generally be provided without the risks and burdens of more aggressive means for sustaining life."⁸⁴

It is not an uncommon process. A congressional report found that 2%-5% of nursing home patients receive tube feeding.⁸⁵ The 1985 Nursing Home Survey found that 26,000 nursing home residents (about 2% of the nursing home population) were tube fed, while industry estimates were that about 4% of the patients were tube fed.⁸⁶

Most medical organizations characterize tube feeding as "treatment." According to the AMA, "[l]ifeprolonging medical treatment includes...artificially or technologically supplied respiration, nutrition or hydration."⁸⁷ The AAN agreed, calling artificial nutrition and hydration "analogous to other forms of life-sustaining treatment" because they "serve to support or replace normal bodily functions that are compromised as a result of the patient's illness."⁸⁸

The federal district court in Rhode Island reflected the opinions of most courts to have considered the issue in finding that "no difference exists between artificial feeding and other life support measures."⁸⁹ It emphasized that "there is no legal difference between a mechanical device that allows a person to breathe artificially and a mechanical device that artificially allows a person nourishment."⁹⁰

Most courts and medical professionals agree that tube feeding has more in common with other medical procedures than typical ways of providing nutrients. Lynn and Childress write that "[m]edical nutrition and hydration do not appear to be distinguishable in any morally relevant way from other

life-sustaining medical treatments that may on occasion be withheld or withdrawn."⁹¹ The Connecticut Supreme Court distinguished feeding tubes from "normal nutritional aids such as a spoon or a straw."⁹² The AAN said that because insertion of the tube into the stomach requires an incision (a gastrostomy), it cannot be considered a nursing procedure, even though nurses and other non-physicians monitor the tube and dosages once it is inserted.⁹³ It calls tube feeding "a medical procedure, rather than a nursing procedure," because "careful medical judgment" is needed before inserting the tube, surgery is required for inserting the G-tube (though not the N-G tube), and, once inserted, "it must be carefully monitored...to insure that complications do not arise."⁹⁴

Some states specifically exclude artificial food and water from the kinds of treatment that can be withheld through living wills.⁹⁵ This lends further support to applying the "treatment" label, because were it not treatment, it would not be included on the lists. Connecticut's failure to include such an exception in its Removal of Life Support Systems Act led its Supreme Court to conclude that the legislature "implicitly contemplate[d] the possible removal...of artificial technology in the form of a device such as a gastrostomy tube, but it does not...permit the withholding of normal nutritional aids such as a spoon or straw."⁹⁶ The court said Connecticut could have followed Missouri's lead and made its law unambiguous: "We note that the statute could have been drafted to require expressly that hydration and nutrition be made available even through artificial devices."⁹⁷

Whether artificially-supplied food and water qualify as treatment is in one sense a merely semantic question, because its label does not affect its morality.⁹⁸ Joseph Bopp argues that "the means by which food and water are provided is not relevant to whether they are classified as medical treatment," because it is the substance of what the patients receive, not the way they receive it that is legally significant."⁹⁹ The method of delivery carries legal significance, however, because

of the large body of precedent that places virtually no inhibitions in the way of an individual's right to refuse treatment. If it is simple nourishment, then its withdrawal is more likely to qualify as suicide or homicide, making it more susceptible to regulation and less tied to a fundamental right based on privacy and bodily inviolability.

Another author argues that providing food and water through tubes is no different from providing air through a respirator but that to base a court's ruling on such a distinction (or similarity) is to blur the relationship between withholding care and death, enabling some to suggest that death comes about from the underlying condition and not from the withdrawal of life support.¹⁰⁰

B. The Persistent Vegetative State

The "vegetative state" is the lowest form of consciousness a human can experience and still be classified as alive. It is one step removed from brain death. A person in a vegetative state loses consciousness of himself, but his lower brain stem still operates. Therefore, he continues to breathe independently, but can do nothing else for himself. Like a baby, he is fully dependent on others. Vegetative patients generally have no sense of the existence or presence of others, nor a sense of hunger or satiety. Many vegetative patients lose their swallowing reflexes.¹⁰¹ They have been described as in a state of "chronic wakefulness without awareness," so that "[d]espite an 'alert demeanor,'...[they] repeatedly fail to demonstrate coherent speech, evidence of the comprehension of words "or any capacity to initiate or make consistently purposeful movements."¹⁰² They can, however, digest food and produce urine,¹⁰³ as well as experience normal cycles of sleep and waking.¹⁰⁴

The "persistent vegetative state," (PVS) then, is nothing more than a diagnosis based on a physician's judgment that the vegetative state will not change. It takes about three weeks

to diagnose a patient as "vegetative" with certainty; by this time, if the condition has not changed, most physicians conclude that it will persist.¹⁰⁵ After a patient has been vegetative for three months, "[t]he diagnosis of permanent unconsciousness can usually be made with a high degree of medical certainty...."¹⁰⁶ A person can survive indefinitely, sometimes up to 30 years, in the persistent vegetative state. There are an estimated 10,000 PVS patients in the United States at any time.¹⁰⁷ Still, some courts struggle with the definiteness of the diagnosis. In trying to determine Claire Conroy's exact medical condition, the sympathetic New Jersey Supreme Court nonetheless called PVS an "imprecise umbrella expression."¹⁰⁸

C. Irreversibility and Terminal Illness

A PVS diagnosis is not infallible. In 1989, a New York trial judge, following his state's controlling precedent¹⁰⁹ as well as other states' rulings, ordered a hospital to honor a woman's request that her PVS sister's feeding tube be removed. The patient, 86 year-old Carrie Coons, had been diagnosed as PVS since a massive stroke six months earlier. At a hearing, the judge heard testimony from a "nationally recognized" gerontologist that Mrs. Coons could persist in her vegetative state for up to two years before dying, but that her condition was "irreversible." Five days after the judge's order took effect, Mrs. Coons broke out of the vegetative state and took food by mouth; the next day she engaged in conversation. When asked if she wanted the tube to be removed, she said "That would be a difficult decision to make."¹¹⁰ "When told she might die if it were removed, or live for several years with it in place, she responded, 'I never thought of it quite that way.'"¹¹¹ Two days later, the judge vacated his order of a week earlier. While physicians considered Mrs. Coons' recovery to be highly unusual, it was not unprecedented, and was attributed, at least in part, to the aggressive efforts of the

nursing staff. The gerontologist later acknowledged that he probably would have ordered further tests on Mrs. Coons had she been younger and, presumably, had "more to live for."¹¹²

IV. REGULATING A FUNDAMENTAL RIGHT

A. Fundamental Rights/Due Process Clause

By simply declaring a right to be fundamental, the Supreme Court effectively places it beyond any limitation. Still, there are standards to apply, malleable though they may be. Fundamental rights receive the highest protection afforded any constitutional right. A state must show a compelling reason to justify the regulation or abridgement of the right.¹¹³ A similarly high standard applies to equal protection analysis under the fourteenth amendment (the fifth amendment does not have an equal protection clause) when a party is a member of a suspect class. In such a case, the state's regulation is subject to strict scrutiny -- another test virtually guaranteeing invalidation of the limitation.¹¹⁴

Equal protection analysis would be relevant in the cases of PVS patients if incompetent patients were to assert that they were being treated different from their similarly-situated (equally sick) but competent counterparts. The Supreme Court never has declared mental incompetents to be a suspect class, but the Court could choose to apply such analysis; it has said that strict scrutiny applies when legislation or state court action impinges on "basic civil rights," a sufficiently expansive construction that could be broadened to include the handicapped in certain settings.¹¹⁵ The Court reserves this highest level of scrutiny for "suspect" or quasi-suspect classes (race, religion, national origin), and employment of it almost always results in invalidation of the challenged classification.¹¹⁶ While the Equal Protection Clause requires that "all persons similarly situated should be treated alike,"¹¹⁷ states receive wide latitude in making social or

economic judgments.¹¹⁸ If no suspect class is involved, a state (or the military or the federal government) normally only need demonstrate a "rational relationship" between its interests and the means chosen to bring them about.¹¹⁹ The Court has adopted an "intermediate level" of scrutiny for evaluating claims of gender-based discrimination.¹²⁰ Given that the rights of handicapped depend to some degree on their setting -- e.g. some "weighing" is permitted when granting access to public facilities and services such as transportation -- such a level of scrutiny that accords some weight to governmental interests could be fashioned for the handicapped. The elderly handicapped are not, in all senses, "similarly situated" with other handicapped such as newborns, but the aged do receive some legislative protection, usually with regard to equal employment treatment, and the Supreme Court has approved such legislative schemes.¹²¹ In the area of withdrawing food and water, government would have to demonstrate that its interests discussed in section IIB below, rationally relate to the means chosen to regulate them.¹²²

Courts increasingly apply the "compelling interest" analysis in the social area. For example, the Supreme Court upheld child labor laws because they protected the interests of individuals against the interests of family members,¹²³ but struck down laws that informed parents about the distribution of contraceptives to their children.¹²⁴ Generally, the limitation cannot be so "unduly burdensome" as to preclude exercise of a fundamental right. For example, the requirements of a waiting period and parental notice and consent were found to place such a burden on the fundamental right of abortion and were struck down in City of Akron v. Akron Center for Reproductive Health.¹²⁵

B. Four Traditional Interests: Are They "Compelling?"

Courts traditionally evaluate limitations on the right to withdraw or withhold nutrition and hydration in light of

four state interests: preservation of life, prevention of homicide and suicide, protection of third parties, and the ethical integrity of the medical profession. Nearly every case evaluating this issue has done so using these four interests as a framework.¹²⁶ These interests apply with equal force to the military. None of the arguments of "military necessity" or the military as a closed society, commonly applied to cases involving first amendment freedoms, applies to expand or restrict application of such factors to servicemembers.

1. Preservation of Life.

The Gray court phrased this question as whether the state can insist that a PVS patient submit to medical care when the patient prefers not to do so.¹²⁷ The state's police power¹²⁸ gives it the authority to enact laws for the general welfare of its citizens [if a federal analysis, as when the Federal Government makes rules for the military, the Constitution's charge to Congress to "provide for the...general welfare"¹²⁹ gives similar authority]. The Supreme Court explicitly recognized this right with regard to medical decisions in 1889: "The power of the state to provide for the general welfare of its people authorizes it to prescribe all such regulations as in its judgment will secure or tend to secure them against the consequences of ignorance and incapacity, as well as of deception and fraud."¹³⁰ New York's highest court found the state's power in this area stemmed from the state's interests as parens patriae (a common justification for juvenile intervention) in protecting life and health of dependent people in grave medical circumstances. In the case of John Storar, a profoundly retarded 52-year old with terminal cancer, a New York court ordered continued blood transfusions because "they could eliminate the risk of death from another terminal cause," even though they could not cure him.¹³¹

In Cruzan, the Missouri Supreme Court characterized the state's interest in preservation of life as "unqualified."¹³²

Despite some criticisms to the contrary, the court emphasized that the right could not be qualified or defined by other factors such as quality of life, not that it was absolute. The interest in the preservation of life protects it on the theoretical or philosophical basis that it should not be lightly discontinued, and on the ground that the state must protect the vulnerable from those with mixed motives or less than pure interests. Even Nancy K. Rhoden, an ardent proponent of "family decision-making" in terminating care, acknowledges that many times family members will have trouble keeping their personal interests (e.g. in being relieved of financial or emotional burdens or in gaining access to wealth) from clouding their decisions about ending treatment for a sick relative.¹³³

2. Prevention of Homicide and Suicide.

The state does not want to permit a person, under the guise of self-determination, to intentionally end his life by exercising a "right" to withdraw food and water. In addition, a state cannot permit a third party to exercise this right and affirmatively end the life of another. This interest is tied to philosophical and jurisprudential definitions on which much of the debate hinges.

If withdrawing food and fluids is merely terminating a version of ordinary care that, but for symbolic reasons is like any other care, then a person or his representative should be allowed to terminate such care without its constituting suicide or homicide. Ethicist Daniel Callahan wrote in 1983, "[t]he only impediment to" a policy of voluntary withdrawal of food and water "is a cluster of sentiments and emotions that is repelled by the idea of starving someone to death, even in those cases where it might be for the patient's own good."¹³⁴ Several courts share his opinion. The Maine Supreme Court said an undue focus on the symbolism of food and water kept Joseph V. Gardner from exercising his right to refuse food and water.¹³⁵ And in Quinlan, the court saw "a real distinction

between the self-infliction of deadly harm and a self-determination against artificial life support," but it never considered food and water to constitute artificial life support.¹³⁶ Contrarily, if food and water, regardless of how delivered, constitute essential sustenance that cannot be terminated, then a person who directs the withdrawal of his own care commits suicide, and the physician is his accomplice; and the third party who directs that it be stopped commits homicide, regardless of his motives or at whose direction he believes himself to be acting. Jed Rubenfeld writes that "courts that have endeavored to differentiate the right to die from suicide have employed distinctions that are not altogether persuasive,"¹³⁷ because if the right to die is in fact "so fundamental to a person that the state may not make it for him, then it is difficult to see on what plausible ground the right to make this decision could be granted to those on life-support but denied to all other individuals."¹³⁸

Justice Lynch in Massachusetts wrote in Brophy that sanctioning the withdrawal of food and water means "everyone has an absolute right to commit suicide...and that others have a right to participate."¹³⁹ He said that when food and water are terminated, "it is not the illness which causes the death but the decision...that the illness makes life not worth living."¹⁴⁰ The Bouvia court, which called suicide "probably the ultimate exercise of one's right to privacy," agreed that the question of suicide is intertwined with the question of cause of death: whether the underlying ailment causes the death or whether the withdrawal of food and water does so.¹⁴¹ Nevertheless, the court opined, "it is immaterial that the removal of the nasogastric tube will hasten or cause Bouvia's eventual death," adding that there is "no practical or logical reason to limit the exercise of this right to 'terminal' patients."¹⁴² In his concurrence, Judge Compton went a step further, arguing that "she has an absolute right to effectuate that decision" to die and that the right "include[s] the ability to enlist assistance from others, including the medical

profession, in making death as painless and quick as possible," especially in the cases of patients "to whom death beckons as a welcome respite from suffering."¹⁴³

Intentionally injuring oneself to avoid duty (malingering) is the closest offense to attempted suicide in the military,¹⁴⁴ but prosecution would be extremely unlikely, not only because the sick or vegetative patient's will would be exercised through another, but also because, in the Army, a regulation expressly authorizes withdrawal of food and water from terminally ill or PVS patients under certain circumstances.¹⁴⁵ The Army does reserve the right to order soldiers to submit to medical care under certain circumstances, regardless of the soldier's preferences. For example, the Army will administer immunizations "to service members without their consent when necessary,"¹⁴⁶ and it requires a soldier "to submit to medical care when necessary to preserve his or her life" or, as the next traditional governmental interest suggests, to "maintain the health of others."¹⁴⁷

3. Protection of Third Parties.

The government traditionally restricts the individual exercise of medical autonomy when such conduct would harm that individual and implicitly harm others or leave them vulnerable; or when adults make such decisions on behalf of minors, leaving the minors subject to injury. For example, courts have ordered blood transfusions despite religious objections, when such transfusions would save the life of a parent (and keep children from becoming wards of the state) or would save a child who had not yet had the chance to independently adopt a parent's religious convictions.¹⁴⁸ None of the leading reported cases in the area of withdrawing food and water has concerned the issue of leaving dependent children as wards of the state.

4. Ethical Integrity of the Medical Profession.

The combination of the highly-regulated status of the medical profession and states' broad police power makes this an important factor. The medical community, as represented by its leading organizations, rejects it as a concern of the courts, however, feeling it is best regulated by itself, particularly in the area of withdrawing care.¹⁴⁹ Many critics argue that the medical community's preference for "aggressive care" causes many of the controversies over withdrawing care, implying that less technology-bound physicians will be more inclined to terminate care.¹⁵⁰ Some interest groups also emphasize the horrors of lost independence that advanced technology brings. One right-to-die advocate wrote in 1984: "The elderly are frightened.... They see a lifetime of control over their own lives eroded at the end by a battery of medical decision-makers who are intent on keeping them alive without thought to their dignity or desires."¹⁵¹ If their governing bodies provide any indication, physicians seem to support liberal standards for withdrawing care. Also, in few of the major reported cases do courts record that physicians have opposed withdrawing food and water.

Nurses, on the other hand, seem to favor more aggressive treatment. Much of the credit for the recovery of Carrie Coons was attributed to the nursing staff, and Nancy Cruzan's nurses told National Public Radio that they believed she was soothed by their elementary care for her.¹⁵² The famous case of the "Bloomington baby," which triggered federal efforts to require the feeding of handicapped newborns, was brought to the fore by a revolt of nurses in the intensive care unit, who refused to deny nutrition to the child, who was born with Down's syndrome and a correctable obstruction in the esophagus.¹⁵³ Currently, the Florida Supreme Court is considering the case of Estelle Browning, who died despite a nursing home's refusal to honor her physician's direction that she not be fed. The court will consider whether the nursing home was bound to respect the physician's order, based on Mrs. Browning's living will, which directed that she not be fed in the event of a

major calamity such as the disabling stroke from which she was suffering.¹⁵⁴

Another issue involving the integrity of the medical profession relates to protection of health care professionals and hospitals that refuse to comply with life-ending directives. Some states have required them to transfer the patient to other professionals or facilities that will comply with the directives.¹⁵⁵

While nearly every case cites the four interests above, nearly every case rejects them, alters them or manipulates them to its own end, because courts in 18 states and the District of Columbia have ruled that no state interest outweighs an individual's right to refuse artificial life support. Most, but not all, cases involved withdrawing feeding tubes.¹⁵⁶

C. Rights for Competents and Incompetents

Central to the decision-making process about a PVS patient is the question of whether competent and incompetent patients have the same constitutional rights. Both sides to the debate have an interest in the answer. Those supporting the right to refuse treatment argue that incompetents have the same rights -- and that, therefore, third parties must be allowed to execute them in their stead, either by doing what the incompetent would have wanted done ("substituted judgment" test) or by making an "objective" determination of the incompetent's "best interests" through balancing the benefits and burdens of continued treatment.

Those who do not recognize such a right to refuse treatment also insist that incompetents have the same rights as competents -- to life and equal protection under the fifth and fourteenth amendments -- and that these rights cannot be abridged by others based on a patient's incompetence. They assert that agents who make such decisions on behalf of incompetents effectively forfeit incompetents' rights (to continued life) by exercising the right to refuse treatment.

It is, however, well established that agents may act on behalf of incompetent patients and that to deny such an option to incompetents "would have the absurd result of granting less protection to those incompetent patients who are in greater need of it."¹⁵⁷ It is true, as the Seventh Circuit observed, that the incompetent patient "will not really be able to 'make' these decisions on his own. But this simply means that someone else acting in the patient's best interests will have to make the decision for him."¹⁵⁸

In light of the growing consensus that countenances withdrawal of food and water, incompetent patients are left without any real protection when agents and courts make decisions on their behalf. Certain rights are, literally, inalienable when their exercise on behalf of an incompetent can have no benefit to the incompetent -- unless the incompetent's death by starvation is seen as a benefit.

Professor Tribe argues that a third party cannot exercise rights if no such rights can reasonably be attributed to the incompetent in his current state: "[A]ttributing 'rights' to these [PVS] patients at all is somewhat problematic. ...To be sure, these patients are not 'dead'...but the task of giving content to the notion that they have rights in the face of the recognition that they could make no decisions about how to exercise any such rights, remains a difficult one."¹⁵⁹ Another author found irony in attributing a right to privacy to the PVS patient and then allowing a third party to exercise it: "The right of privacy is the right to choose, and can only belong to a person competent to exercise that right. ...The time for asserting the right, like the time to execute a will or vote, simply expires when the patient can no longer exercise it."¹⁶⁰ The Supreme Court has not addressed the extent to which fundamental rights or the "right of privacy" can be exercised by third parties. It did hold, however, that the decision whether to perform an abortion (specifically, the right of an adult to stop a minor from exercising her fundamental right to get one) could not be exercised by a third party, because the

right is purely personal.¹⁶¹

V. EVIDENTIARY TESTS and STANDARDS

In deciding whether to permit withdrawing nutrition and hydration, courts have employed several tests and evidentiary standards. All of these assume that at some time under some circumstances food and water may be withdrawn, turning the inquiry to how to implement the right and who will make the decision for the incompetent patient. The choice of test and the application of evidentiary standards are crucial, because such choices frame the final decision, though one scholar believes that courts create elaborate tests because they are hesitant to expressly make the underlying judgment about the patient's quality of life. Therefore, Professor Destro writes, "the focus in the 'hard cases' now reaching the courts is generally on who shall make the decision, rather than what decisions they should make...[and] the core 'value of life' issues presented by the cases themselves."¹⁶²

A. Substituted Judgment Test

The "substituted judgment" or "limited objective" test seeks to carry out the decision that the incompetent patient would have made. Determining "what the particular patient would have done under the circumstances,"¹⁶³ is, theoretically, an objective process by which competent, knowledgeable people discover what the incompetent would have done. Of course this test cannot apply to the never-competent (for example, the anencephalic newborn and others with severe congenital mental defects). It works best when the once-competent patient left some evidence of his intentions in the event of his becoming vegetative.

The best evidence of such intentions is some form of express directive such as a "living will," a document that makes explicit an individual's desires for what kind of medical

treatment he wants when he is incompetent or close to death. Forty states and the District of Columbia have living will statutes. Of these 41, 14 do not mention whether the living wills can be used to direct the withdrawal of artificial nutrition and hydration,¹⁶⁴ ten expressly say it can be withdrawn under certain circumstances,¹⁶⁵ 12 say it cannot be withdrawn so long as it constitutes comfort care,¹⁶⁶ and five specifically forbid withdrawal of food and water though, as will be addressed later, some state courts have limited the reach of the statutes.¹⁶⁷ Seven states provide for use of durable powers of attorney.¹⁶⁸ These instruments -- called "durable" because they survive the incompetency of their authors -- provide directions similar to living wills, also designating persons to make medical decisions on the patient's behalf. A competent adult can use a living will to direct that medical care be stopped when certain events or conditions come about. A declarant also can stipulate who will make the decisions whether to continue medical treatment. The will can be as specific as its author desires, though several states' statutes provide sample forms that should be followed in those jurisdictions.

Much as with traditional wills, some states' living will statutes set out a hierarchy of individuals (usually in declining order of consanguinity) who will make decisions for the incompetent or dying patient.¹⁶⁹ Once highly controversial, living wills have entered the mainstream and are endorsed or encouraged by consumer groups and insurance companies.¹⁷⁰ The Army, of course, will write and execute them in its Legal Assistance offices.¹⁷¹

Express directives theoretically are self-executing. When contested, however, they are resolved in court in much the same way as conventional wills. Still, it is misleading to imply that even a carefully constructed living will offers the amount of predictability a sick patient or distressed (or divided) family might seek. The highest courts of Washington and Maine overrode express language that prohibited withdrawal of food

and water.¹⁷² On the other hand, most living will statutes do not penalize physicians who refuse to honor living wills.¹⁷³

In the absence of such instruments, cases often land in court, where judges and guardians mine the patient's life history for evidence of what he would have wanted done. They rely on express statements made by the formerly competent person in anticipation of such an event. Failing that, courts look for statements the patient might have made when others close to him were in similar states, in response to news reports of notorious cases, as well as descriptions of his philosophical and religious beliefs (from which attitudes toward his present plight are extrapolated). When courts employ the substituted judgment standard, the information on which to make the judgment comes from those who knew the patient best, usually family and close friends.

The Cruzan controversy well illustrates the problem. The trial court heard testimony from 27-year-old Nancy Cruzan's housemate, a friend and co-worker that she would not want to be kept alive if she were to become a "vegetable."¹⁷⁴ The Missouri Supreme Court overturned the lower courts' permission to stop feeding Nancy, partly because it found the quoted statements to be too casual and informal and, therefore, insufficiently reliable for a decision of such moment. The court said: "A decision to refuse treatment, when that decision would bring about death, should be as informed as a decision to accept treatment."¹⁷⁵ A Massachusetts trial court, however, approved the disconnection of Paul Brophy's feeding tube based on statements such as "I don't ever want to be on a life-support system," "when your ticket's punched, it's punched," and "If I'm ever like that, just shoot me, pull the plug."¹⁷⁶ Similarly, the Maine Supreme Court found enough evidence in the recollected statements of 23 year-old Joseph V. Gardner to rule that he would have wanted his feeding tube disconnected. Gardner became vegetative after a fall from a pick-up truck. The court said he had told his girlfriend two years before the accident that he would "want to die," rather

than remain subject to life-sustaining procedures, and that a month before the accident he had told a friend "in a very serious manner that he 'would definitely want to die if he was ever in a vegetative state.'"¹⁷⁷ The court determined from these statements that "what was on Gardner's mind was not only the invasiveness of...the NG tube" (though the statements were not specific about what kind of life-sustaining procedures revolted him) but "also the utter helplessness of the permanently comatose person, the wasting of a once strong body...."¹⁷⁸

The substituted judgment standard was most recently endorsed by the Illinois Supreme Court, which ruled in late 1989 that an "irreversibly comatose" or persistently vegetative patient may have food and water withheld when there is "clear and convincing evidence that the refusal is consistent with the patient's interests," and two physicians agree.¹⁷⁹

B. "Objective" or "Best Interests" Test

Courts employ the "Best Interests" test for patients who did not indicate their preferences before becoming incompetent (or did so inadequately, in the court's eyes) or who never were competent. If a court cannot find evidence for applying the substituted judgment test, it seeks to determine the patient's best interests by balancing the "benefits and burdens" of continued treatment. Such analysis, in this case balancing the benefits of being fed against the burdens of being kept alive by artificial feeding, flows from the law governing informed consent.¹⁸⁰ Therefore, courts have to attempt to balance the benefits and burdens of continued nourishment in deciding whether incompetent patients and patients without living wills should continue to be fed. The New Jersey Supreme Court, though preferring the substituted judgment test, wants the option of employing the best interest test for this part of the population because to do otherwise would "foreclose the possibility of humane actions, which may involve termination of

life-sustaining treatment for persons who never clearly expressed their desires...but who are now suffering a prolonged and painful death."¹⁸¹

Assuming the existence, at least in some cases, of the right to terminate nutrition and hydration, this standard is far more controversial -- and malleable and subject to abuse and infusion of third party values -- than the substituted judgment standard. It is still true that the great majority of people do not make advance directives about near-death treatment. People do not like to contemplate death.¹⁸² They are unfamiliar with instruments such as living wills, and many "hard cases" stem from trauma such as automobile accidents, which disproportionately affect the young -- or war, which disproportionately gives vegetable-inducing head injuries to young men. About 10% of the population has some form of a living will.¹⁸³

Courts and commentators frequently address the following burdens:

1. No Consciousness, No Pleasure: That a patient cannot experience normal human feelings or emotions or know that he is experiencing them. Because PVS patients have no consciousness or sentience and cannot experience joy or (most physicians say) pain, many critics argue that their continued existence is meaningless.¹⁸⁴ The AMA reported that PVS patients "do not have the capacity to experience pain or suffering. Pain and suffering are attributes of consciousness.... ...[D]irect clinical experience with these patients demonstrates that there is no behavioral indication of any awareness of pain or suffering."¹⁸⁵ Thad C. McCanse, Nancy Cruzan's guardian ad litem, said artificial feeding is "keeping her alive as a mindless mass of human flesh with no future. She's not someone you can think of in connection with enjoying life. There's no benefit to her [in staying alive]."¹⁸⁶ The Quinlan court quoted a neurologist, testifying for the state as declaring, "The subject has lost all human qualities."¹⁸⁷

This argument, made more equivocally by others, ties a patient's personhood and her presumed desire for further existence to the commonly-understood aspects of consciousness, especially pleasure. It assumes that the patient is no longer fully human because she cannot experience life the way we expect humans to do so; therefore, the value of her life is lessened and commands less protection. Professor Destro argues that "[u]nder a natural rights approach, one need only be genetically human to be entitled to equal protection,"¹⁸⁸ but others argue that the legal system should not confer the benefits and protection of personhood in such a blanket manner.

2. Mere Maintenance: That because PVS patients have no realistic hope of recovery, treatment is at best an expensive form of maintenance. The AMA believes that artificial nutrition may be discontinued for PVS patients because "it merely prolongs or suspends the dying process without providing any possible cure."¹⁸⁹ The President's Commission agreed: "If a prognosis of permanent unconsciousness is correct, however, continued treatment cannot confer such benefits [as]...preserving life, relieving pain and suffering, protecting against disability, and returning maximally effective functioning." (The Commission considered nutrition and hydration to be treatment.)¹⁹⁰ New York's highest court, in deciding the case of a gangrenous 74 year-old stroke patient who was receiving artificial feeding, said, "she is for all practical purposes merely existing. ...Life has no meaning for her. She derives no physical or emotional pleasure or any degree, nor any intellectual satisfaction in her day to day existence. She will remain completely dependent on others..."¹⁹¹

Quality of life considerations are most explicit when couched in terms of a patient's being passively maintained, out of her control, by machines that feed her. Allen Buchanan writes that withholding food and water "seems to be no more in [a patient's] best interests than refraining from watering a

plant could be said to be good for it."¹⁹² But he makes sure that his readers do not miss his point: a plant can do no better; for a human vegetable, such an existence is a meaningless form of organic functioning, and therefore may be terminated or "allowed to end."¹⁹³ Rhoden uses the same analogy, agreeing that it "makes no more sense to attribute an interest in continued life to a persistently vegetative person than it does to attribute such an interest to a plant."¹⁹⁴ Still, none of these critics can demonstrate any real harm to a patient from being maintained alive in a vegetative state. Destro observes: "[I]t is stretching the concept to its breaking point to assert that death is in a patient's best interests whenever the intervention will do nothing more than palliate or maintain."¹⁹⁵

3. Diminished Dignity: That continued treatment assaults a patient's dignity. Physicians pledge to uphold a patient's "human dignity."¹⁹⁶ The AMA counsels that in making a decision about life-prolonging treatment "the physician should determine what the possibility is for extending life under humane and comfortable conditions...."¹⁹⁷ Keeping a patient artificially fed "degrades the very humanity it was meant to serve,"¹⁹⁸ meaning that disconnecting such treatment from a hopelessly ill person enhances her dignity. The neurologists agree: "The undignified state in which a patient is maintained constitutes one burden imposed by the treatment."¹⁹⁹

4. Life Qua Life Has No Value: That life in the abstract is of no benefit to the PVS patient, so that the state then has no grounds to intercede. This does not necessarily posit that mere existence is a burden for the PVS patient as in "wrongful life" cases (he is, after all, oblivious to everything), but that it is not and can never again become a benefit. This position received judicial approbation when the New Jersey Supreme Court permitted Eberhard Johanning, acting on a durable power of attorney authorizing him to make "all medical

decisions" for Hilda Peter, to order removal of her feeding tube.²⁰⁰ The court said: "We find it difficult to conceive of a case in which the state could have an interest strong enough to subordinate a patient's right to choose not to be artificially (sic) sustained in a persistent vegetative state."²⁰¹ The American Academy of Neurology expressed its members' position that such a life is not worth living: "It cannot seriously be argued that anyone would choose to be sustained for years in a...[persistent vegetative state] with absolutely no hope of even reviving, much less recovering. ...The state's interest in life...is a nullity in the case of the PVS patient."²⁰²

Peter Singer, of Yale's medical school, agrees: "Once the religious mumbo-jumbo surrounding the term 'human' has been stripped away, we may continue to see normal members of our species as possessing greater capacities of rationality, [etc.]...but we will not regard as sacrosanct the life of each and every member of our species, no matter how limited its capacity for intelligent or even conscious life may be. If we compare a severely defective human infant with a nonhuman animal like a dog or a pig, for example, we will often find the nonhuman to have superior capacities."²⁰³

5. Invasiveness: That the feeding tube's inherent invasiveness makes it a burden; that is, that death by starvation and dehydration is preferable to maintenance on the tube. The Brophy court found that long term maintenance of a PVS patient (bathing, shaving, tending to bowels and bladder, turning and feeding) "is intrusive as a matter of law," although the trial court found it to be "the least intrusive, least invasive and most problem-free way of providing nutrition and hydration to him."²⁰⁴

Attributing such burdens to a PVS patient assumes a consciousness that the same medical community agrees he does not possess. Therefore, ascribing this burden to the PVS patient rests on third parties' vicarious sense of the burden.

They also tie the burden to pain, despite the belief that the PVS patient is oblivious to that as well. For example, one interest group says the "gastrostomy is only one of a number of burdens suffered by unconscious patients. Patients in a persistent vegetative state do not rest peacefully."²⁰⁵ The Brophy court noted that they do not die peacefully, either, and "that death by dehydration is extremely painful and uncomfortable for a human being." It said that after his feeding tube was disconnected:

Brophy's mouth would dry out and become caked or coated with thick material. His lips would become parched and cracked. His tongue would swell, and might crack. His eyes would recede...and his cheeks would become hollow. The lining of his nose might crack and cause his nose to bleed. His skin would hang loose on his body and become dry and scaly. His urine would become highly concentrated, leading to burning of the bladder. The lining of his stomach would dry out....His temperature would become very high...brain cells would dry out, causing convulsions. His respiratory tract would dry out, and the thick secretions that would result could plug his lungs and cause death. At some point within five days to three weeks, his major organs would give out and he would die.²⁰⁶

Ronald Cranford agrees that it could take up to a month for a patient to starve, but says it need not be painful. "If given adequate nursing care during this withdrawal [from food and water]...PVS patients will not manifest the horrible signs ascribed to this process by some...nor will they experience consciously any symptoms."²⁰⁷

6. Others are burdened: That parents, spouses and caregivers shoulder crushing emotional and financial burdens

in caring for a PVS patient, especially when the patient lives for years. It can cost them their savings and consume their time and their thoughts, all with not a hint of reinforcement or thanks from the permanently nonresponsive PVS patient. The AMA has argued that "people care about the memories they leave behind them" and that a PVS patient's "freedom to minimize the suffering of others" supports withholding nutrition and hydration from the patient.²⁰⁸ The Society for the Right to Die believes that a patient might want food and water withdrawn out of "a personal desire to spare one's family prolonged agony...or a specific choice to leave one's money for the education of grandchildren, rather than the profits of a nursing home."²⁰⁹ The President's Commission made similar observations, writing that "most people...have an important interest in the well-being of their families...whose welfare, most patients, before they lost consciousness, placed a high value on."²¹⁰ The extent to which burdens on others qualifies as a legal basis for denying medical care to a sick patient is highly problematic, however.

In the Army, families are less likely to have to bear the financial burdens of care, but the incalculable emotional burdens will be no different from the civilian world. The Conroy trial judge well summarized the conflicting emotions of sympathy and frustration (and utilitarianism) when he observed, "I think it is fair to say that everyone involved in this case wishes that this poor woman would die."²¹¹

C. Extraordinary and Ordinary Care

Another aspect of the analysis is the distinction between ordinary and "extraordinary" care. No longer a controlling distinction, it still prompts discussion by some courts. Originally advanced by Pope Pius XII, it is comparable to the benefits-burdens balancing. The theory, as advanced by the Catholic Church, requires employing all care (ordinary) that do not create "grave" burdens for patients or others.²¹² Such

burdens would be evaluated "according to the circumstances of person, places, time, and cultures,"²¹³ so that inventive forms of feeding possible with contemporary technology could become "ordinary" means (and therefore compelled), even though they might once have been extraordinary. [The Church's more recent statements on the issue use the terms "proportionate" and "disproportionate" in place of ordinary and extraordinary.²¹⁴] The technology that keeps PVS patients alive has developed only in the past 30 years.²¹⁵ While some criticize the ordinary-extraordinary distinction as outmoded,²¹⁶ the Brophy court used it, emphasizing that the degree of care fits on a sliding scale such that "what was viewed as extraordinary care ten years ago might be considered ordinary care today."²¹⁷ Critics emphasize that such a distinction is irrelevant -- and that practically any care is then "extraordinary" -- "[w]herever personality and personhood are permanently lost."²¹⁸ This echoes the Quinlan court, which was not prepared to adopt the distinction as a legal test but said a respirator constituted ordinary care in the case of the "possibly curable patient but 'extraordinary' in the context of the forced sustaining...of an irreversibly doomed patient."²¹⁹

VI. LIMITATIONS: The Tests Converge

A. The Tests are Legally Indistinct

So long as 90% of the population does not have living wills, courts will have to turn to some form of an objective or "best interests" test to determine whether food and water can be withheld from a patient. Judges will have to sift through snippets of reconstructed conversations and casual remarks in their efforts to credibly discern the intent of the patient. As these data become more remote and the courts move toward a best interests test, they will have to grapple with how to determine the benefits and burdens for this patient, given that his values, beliefs and inclinations are the only

ones that should control the decision for him. This approach leads to intellectual dishonesty and the most porous of legal reasoning, since the remarks of the patient often are too remote or too casual to have the weight the courts seek. While this leads a few courts (such as New York in the O'Connor case) to deny the petition to end the feeding, it prompts most to finagle the tests to produce the desired results.

Professor Rhoden, who supports the right to die, nonetheless argues that courts "have stretched the concept of an incompetent's right to choose past its breaking point" in pretending to discern a patient's intent from the statements and recollections of others.²²⁰ Professor Destro, who generally does not support such a right, agrees. He argues that only when an individual has a living will "is it accurate to say that the individual's right to autonomy is exercised by proxy;" the substituted judgment test, he asserts, lies "clearly within the realm of legal fiction."²²¹ Courts refuse to face that "no matter how scrupulously performed," objective tests all rely "on the proxy's values in addition to the patient's because it is impossible for a proxy not to infuse such an inquiry with his own values."²²²

In fact, the two tests blur and, ultimately, merge because neither can be performed without the assistance of third parties, and all third parties have values that influence the process. Rhoden agrees that the "subjective and objective standards are not so distinct [and] that uninvolved third parties are not necessarily capable of better or more fully objective choices."²²³ In addition only conjecture can answer whether a patient whose substituted judgment is being enforced might have changed his mind had he known how miserable he would be or how much he would crave life. To not consider this would appear to deprive the patient "of the benefit of the doubt that...with so much as stake, he or she might act more reasonably than earlier behavior would have us believe."²²⁴ Yet, as two critics argue, allowing for such flexibility destroys the test: "Clearly, once one attempts to build into

the substituted judgement determination the notion of changed circumstances, the way is paved for applying the same largely arbitrary 'best interest' considerations with their attendant conscious and unconscious biases."²²⁵

As soon as a court tries to balance the burdens and benefits of a particular case it finds values not quietly infiltrating but marching through the door. Professor Rhoden inadvertently illustrates this point. Despite criticizing such balancing tests, she offers a set of factors for judges to employ that includes the amorphous ("lifestyle" and "values"), the hard to measure ("pain"), as well as the value-laden ("projected life span" and "ability to interact with others and the environment"),²²⁶ that others might reject. This only reinforces the thrust of her critique: that objectivity is not achievable in this area and that "even if we could achieve neutrality, we would probably lack values by which to judge the life's benefits and burdens."²²⁷

The Beth Israel court listed 12 factors to weigh in deciding whether to order treatment. They included age, life expectancy, pain, "mental disability and degree of helplessness," opinions of the physician and "those close to" the patient and "whether there are any overriding State parens patriae interests in sustaining life."²²⁸ These divergent checklists show that whoever constructs the tests (and thereby decides what will be a burden or a benefit) or, as section VI will address, selects the evidentiary standard, controls the result. The President's Commission's inclusion of a patient's burdensomeness to others²²⁹ as balancing factor, and its suggestion that decisions to terminate food and water be based on the views of "the average, reasonable person in the patient's position"²³⁰ "introduces precisely the quality-of-life standard it eschews by permitting the well-being of others to be counted as a factor in determinations regarding the value of the patient's life."²³¹ "In these cases, someone else makes the decision for the incompetent person or child, and the right to individual autonomy is simply irrelevant."²³² It is the fact

that terms such as privacy have no content until fleshed out by the courts that makes this an area of no real legal discipline or predictability. Justice Handler in New Jersey wrote that "reliance upon the concepts of personal privacy and individual autonomy cannot enhance the ability to make critical life-or-death decisions."²³³

It is important to face the inherent limitations of such a decisionmaking construct and the dearth of workable alternatives. As Richard Burt argues, courts in these cases are making judgements about whether the prospective quality of a patient's life justifies continuing to feed him (and to continue burdening a family with the attendant obligations of cost, time and emotional involvement).²³⁴ One person is deciding whether another person will die. He does so, however, through the fiction of ascribing to the incompetent patient beliefs he may not hold and powers of choice he truly does not have. The Conroy court demurred:

We do not believe that it would be appropriate for a court to designate a person with the authority to determine someone else's life is not worth living simply because, to that person, the patient's "quality of life" or value to society seems negligible. The mere fact that a patient's functioning is limited or his prognosis dim does not mean that...it is in his best interests to die. ...More wide-ranging powers to make decisions about other people's lives...would create an intolerable risk for socially isolated and defenseless people suffering from physical or mental handicaps.²³⁵

Justice Lynch, however, insists that an incompetent patient no longer has a right of autonomy that he can exercise. He said the substituted judgment test, employed by the Brophy majority "is paternalism masquerading as the mere ratification of autonomous choice."²³⁶

Stripped of its rhetoric, and of terms such as "autonomy"

and "self-determination," the balancing turns on whether, after totting up the benefits and burdens, death is in a patient's best interests. Separate from the emotion that affects both sides, this line of thinking does not rely on solid or predictable legal principles. The process is interwoven with a narrow, functional view of the value of human life. So long as death is an option, when it is brought about by starvation the only argument is over the unresolvable: how much weight to give to the inherently subjective, emotional factors courts call the benefits and burdens of life. Justice Handler encourages courts to "more directly confront, rather than finesse, the difficulties intrinsic to the objective approaches," and to address the quality of life forthrightly.²³⁷ Destro agrees with the judge's critique:

Where the individual is severely disabled, terminally ill or incompetent, however, the courts have usually hidden behind the fictions of individual autonomy, an expansive definition of treatment (which now includes feeding)...all in order to avoid the question of whether or not death is in the child's or incompetent's best interests.²³⁸

Because the calculation of benefits and burdens is value-infused, and there is no societal consensus on when (or whether ever) a patient should not receive food and water, the law should not intrude in the area. When the law cannot base its decisions on such discoverable, societally-based standards, it should not create rights and make decisions that could prematurely end the life of a citizen. Courts are at their most dangerous when they seek to create tests to match their desired results. The substituted judgement standard relies on untestable statements and data and, as Professor Emanuel observed, so long as there are no "societally shared criteria

the best interests standard is vacuous."²³⁹

B. An Alternative: Family as Decisionmaker

Although she argues persuasively that courts employ elaborate fictions to justify permitting the withdrawal of food and water, Professor Rhoden nonetheless believes that such decisions should be permitted -- only that they should be forthrightly based on a "presumption in favor of family decision-making that mirrors the deference to a competent patient's choice."²⁴⁰ Rather than pretending to implement a choice that an incompetent patient cannot make -- or presuming he would have made it if competent²⁴¹ -- Rhoden asserts that family members are the best proxy decision-makers. Many critics and jurists have suggested family members as the best decisionmakers, extrapolating from Supreme Court precedent a strain of thinking purporting to elevate the family to primacy in making such "intimate" decisions. Such deference to the family would eliminate, or at least make less stinting, the scrutiny of the agent's motives.

The Supreme Court has, in fact, extended constitutional protection to many matters involving the family.²⁴² Recently the Court spoke of the "sanctity" of intra-family relationships when upholding California's presumption that children born of a marriage were conceived of the same marriage.²⁴³ In Roberts v. United States Jaycees, the Court said that parent-child relationships are "woven into the fabric of our society."²⁴⁴ Rhoden argues that parents know their children's values because they are instrumental in inculcating them and that spouses know each other's values because they often develop them jointly.²⁴⁵ It is true, of course, as the Supreme Court has observed, that families form "emotional attachments that derive from the intimacy of daily association,"²⁴⁶ but the deference this generates usually is limited to parental decisions regarding education (e.g. Yoder and Pierce), and medical decisions (except for abortions or religion-based refusals of treatment),

and does not extend to other family members.²⁴⁷ There is no precedent for such deference with regard to the medical choices of an adult.²⁴⁸

In the area of withdrawing food and water, an unmistakable trend of deference to families already is evident, even though different courts express it in different ways. The Connecticut Supreme Court said that the unanimous support by Carol M. McConnell's husband and children for withdrawing her feeding tube merited great weight in its decision to approve the termination of her feeding.²⁴⁹ The New Jersey Supreme Court noted that family members are most likely to know a patient's philosophical, religious and moral attitudes toward sickness and death.²⁵⁰ The court said: "Family members are best qualified to make substituted judgments...not only because of their peculiar grasp of the patient's approach to life, but also because of their special bonds with him or her. ...It is they who...treat the patient as a person, rather than a symbol of a cause."²⁵¹ That same intimacy also can yield bitterness, jealousy and greed of the kind that can cloud the motives and judgment of those seeking to help a court assess the subjective judgment or best interests of a sick, incompetent relative. As Ira Mark Ellman writes, it is a romantic illusion to assume that families have any special capacity to put aside impure motives and yield only wise decisions:

Indeed, family members are often subject to pressures that conflict with the patient's interests. These pressures are not only financial. Prolonging the dying process may also enlarge the emotional price they pay, preventing them from bringing their mourning to closure; daily exposure to a close relative ravaged by disease is another burden that ends with the patient's death. Meeting the patient's...needs may impair the relatives' ability to meet their obligations to other family members, including their own children.²⁵²

C. Selecting an Evidentiary Standard

Once a court decides which test to employ, it must decide what evidentiary standard to apply in determining the accuracy of the substituted judgment or in weighing the patient's best interests. If the standard is set too high, it can negate or make impossible the exercise of the right.

"Substantial" evidence and "preponderance" of the evidence are the lower, common, administrative evidentiary standards. Never employed for criminal verdicts, they are used to test routine administrative classifications and actions by governments.

The "clear and convincing" standard is the highest used in noncriminal, civil proceedings.²⁵³ The Supreme Court has shown an inclination to increase the evidentiary standard when the stakes are high for the affected person's life or liberty. In 1979 the Court held that more than a preponderance of the evidence was needed when evaluating procedural due process necessary in precommitment decisions for the mentally ill.²⁵⁴ The Court also sanctioned the use of this more stringent evidentiary standard in cases involving termination of parental rights.²⁵⁵ New York required the continued feeding of 77 year-old Mary O'Connor, a stroke victim, because it found that her two daughters did not present clear and convincing evidence that their widowed mother would not have wanted to be fed by a nasogastric tube.²⁵⁶ The court acknowledged that requiring clear and convincing evidence of Mrs. O'Connor's wishes "presents inherent problems," because there is no way to definitely know the answer to that question -- given that the patient's incompetence created the situation.²⁵⁷ The court said there at least must be clear and convincing evidence "that the patient held a firm and settled commitment" over some time that she would not want nutrition in such circumstances.²⁵⁸ Mrs. O'Connor had called "monstrous" the artificial life support to which some friends and family had been subjected, but the court believed that the "expressions were nothing more than immediate

reactions to the unsettling experience of seeing or hearing of another's unnecessarily prolonged death."²⁵⁹

In dissent, Justice Simons said that refusal to honor such statements "requires humans to exercise foresight they do not possess," to anticipate the exact types of life sustaining treatment they might want to terminate, and that failure to honor statement such as Mrs. O'Connor's discriminates against those without living wills.²⁶⁰ However, his fellow justice said that relying on such statements assumes the statements would remain true when a patient was faced with the choice of death. In such a circumstance, Justice Hancock argued, the law must be especially conservative and cautious. While calling the clear and convincing standard unworkable because it presumes to find "a fact which is inherently unknowable," he said any such process is "nothing more than a calculated guess" and "there is simply no way of excluding the possibility that the patient has had a change of mind so that her past statements do not indicate her present wishes."²⁶¹

This higher standard has been criticized as too restrictive when used in cases of withdrawing medical care, but courts in New York (other than O'Connor), Maine, Illinois, and sometimes New Jersey have used it and still ruled in favor of withdrawing food and water.²⁶² The New York Times editorialized that such a strict standard results in secret decision making, forcing clear-cut cases into court or mandating treatment for patients who should be allowed to refuse it, but for whom clear and convincing evidence is not available.²⁶³

Again, Professor Rhoden argues that the clear and convincing standard, like the choice of tests, yields equally undesirable results: a) keeping patients unnecessarily hooked to feeding tubes, or b) intellectual craftiness by attorneys and judges who evade the legal standard they purport to employ. Rhoden calls the clear and convincing standard "a mismatch" with an area of that law that is bound to rely on recall, intuition and "knowledge that is not rationally provable."²⁶⁴ She writes that this evidentiary standard either leads to bad

results by honest judges (a bad result, in her opinion, being continued feeding of a PVS patient who should be permitted to die, as in O'Connor)²⁶⁵ or "opinions that misleadingly imply that such a justification is possible "when they are really masking a values-based decision."²⁶⁶ The President's Commission, however, recommended use of "especially stringent standards of evidence" to insure that its "reasonable patient" standard was not skewed by the personal or financial pressures or prejudices of those making the assessment.²⁶⁷

VII. The U.S. MILITARY'S POLICIES

A. No Consensus

The military services do not share a consensus on the issue. The Army leads the other services, having promulgated a regulation and policy letter that address withholding and withdrawing food and water, as well as circumstances for honoring do-not-resuscitate orders.²⁶⁸ The Air Force relies on three policy letters from 1980 and 1982 that advise physicians to read Quinlan and a magazine article for guidance, and to follow state law.²⁶⁹ The Navy has no regulation at all.

B. Army Permits Withdrawing Food and Water

The Army regulation permits withholding or withdrawing life-sustaining care from a terminally ill or "chronically vegetative" (the same as persistently vegetative) patient when a guardian or next of kin and attending physician agree.²⁷⁰ If those parties disagree (i.e. the physician wants to terminate the care), the case should be reviewed by the hospital's ethics panel.²⁷¹ The regulation expressly includes food and water in its description of the kinds of care that can be withdrawn or withheld.²⁷² It says that the following factors should be weighed when determining whether continued care is in a patient's best interests:

(1) Relief of suffering, (2) Quality as well as extent of life sustained, and (3) "Substituted judgment doctrine": What the patient would have wanted if competent. If an incompetent patient has no family or legal guardian and the treating staff concludes that withdrawal of life-sustaining treatment is proper, consultation should be undertaken with the DCCS and the Ethics Panel.²⁷³

C. Mixed Legal Standards, Ambiguities

The above paragraph mixes the legal standards used to evaluate petitions to withdraw care ("best interests" and "substituted judgment") and gives no hierarchy to the factors listed. The regulation suffers from several other ambiguities, and tilts decisively in favor of terminating life-sustaining care. For example:

1. It fails to give standards by which to determine whether a patient is "terminally ill," and therefore eligible to stop receiving food and water. Currently, the term is subject to definition by (or argument among) the physicians or next of kin. The term is not easy to define, but should not stand alone in a regulation without an attempt to define it, to the extent it is at all a descriptive medical term. As the Supreme Court explained in a case involving an effort by some terminally ill cancer patients to gain access to the drug Laetrile, "it is often impossible to identify a patient as terminally ill except in retrospect."²⁷⁴ The Court continued: "[N]o one can prospectively define the term 'terminal' with any accuracy. A patient can be said to be terminal only after he died."²⁷⁵

2. It does not define next of kin.

3. The statement of policy says that the Army "is committed to the principle of supporting and sustaining life when it is reasonable to do so."²⁷⁶ It does not further define reasonableness, though it implies that anything that will not cure a patient might be unreasonable: "Life-supporting techniques and the application of medical technology may not cure a patient's disease or disability or reverse a patient's course."²⁷⁷

4. The policy statement says that some treatment that results in a cure "may reach a point where [it is]...medically unsound."²⁷⁸ It does not define medical soundness.

The policy's "right to die" bias, implied in the suggestion that treatments that do not result in cures might not be reasonable, is reflected in its statement that an "attending physician must decide whether continued efforts constitute a reasonable attempt at prolonging life or whether the patient's illness has reached such a point that further...care is in fact merely postponing the moment of death which is otherwise imminent."²⁷⁹ This policy presupposes that such a life has no value. It also carries an ambiguity. Whereas the policy applies to terminally ill and PVS patients,²⁸⁰ this sentence does not apply to PVS patients, because their death normally is not imminent, hence the "chronicness" or "persistence" of their condition -- and the controversy over their burdensomeness.

D. Ethics Panels

The Army directs that conflicts between patients and physicians be referred to hospital ethics panels. It says that failure to reach agreement before referral will require continued life-sustaining treatment "until reasonable agreement is reached."²⁸¹ The composition of the ethics panel is vague. "A representative of the local staff judge advocate" is the only member the regulation mandates.²⁸² Otherwise, it directs

only that "[m]embership should be balanced" and that panels may include members "drawn from administration, medicine, nursing, pastoral care, social work or the community."²⁸³ Such panels remain in their infancy in the Army and nationwide. A 1983 report found that only 1% of the nation's nearly 7,000 civilian acute care hospitals had functioning ethics committees, while 4.3% of teaching hospitals had them.²⁸⁴ As of 1988, only one-third of the Army's hospitals had ethics committees.²⁸⁵ A chaplain with experience on Army ethics panels has found that the priority placed on such committees "varies according to the emphases accorded by the hospital commander and the committee chairperson."²⁸⁶

VIII. THERE is NO CONSTITUTIONAL RIGHT to WITHDRAW
FOOD and WATER

The Supreme Court will decide the Cruzan case in 1990. The issue would best be resolved by recognizing that there is no federal constitutional right to withhold or withdraw food and water, regardless of how it is provided to a patient. Assuming that the Court leaves such regulations to the states -- any decision other than constitutionally embracing a "right to die" -- the military should avoid the morally problematic and legally tangled possibilities raised by trying to implement the right in the military. The military should not implement such a right, and its regulations that attempt to do so should be rescinded. This section will analyze and anticipate the Supreme Court's treatment of the area and recommend a course of action for the military.

In Cruzan, the Court is likely to follow Bowers in refusing to embrace a new constitutional right and Webster in leaving the regulation of the right to die to the states. In Webster, the Court loosened the limitations on states' rights to regulate the practice of abortion. Writing for the Webster majority, Chief Justice Rehnquist said states were free to make their own value judgments favoring childbirth over abortion and

implementing such judgments through the expenditure of public funds.²⁸⁷ The majority said that such state judgments did not have constitutional implications (notwithstanding the "fundamental" right to abortion) and, crucial for the right to die, the Court said states may implement such value judgments through the allocation of public resources, including hospitals and medical staff. "[P]rivate physicians and their patients [do not] have some kind of constitutional right of access to public facilities for the performance of abortions."²⁸⁸ It said such judgments are purely those of the state legislatures, subject to political control by the voters.²⁸⁹

While the Bowers court made clear its reluctance to continue divining fundamental rights from the Constitution, the Webster decision emphasized that this was especially true with regard to the regulation of medical decisions, which calls for detailed rule-making of the kind legislatures are uniquely competent to do under our constitutional structure:

The key elements of the Roe framework... are not found in the text of the Constitution or in any place else one would expect to find a constitutional principle. Since the bounds of the inquiry are essentially indeterminate, the result has been a web of legal rules that have become increasingly intricate, resembling a code of regulations rather than a body of constitutional doctrine.²⁹⁰

The Court said it was frustrated at serving "as the country's ex officio medical board with powers to approve or disapprove medical and operative practices and standards throughout the United States."²⁹¹

A decision along these lines in Cruzan would make enormous difference to the military, because it would mean that individual entities (normally the states, but also the federal government and military for their own hospitals) will be permitted to regulate the procedures for withdrawing medical care, subject to minimal review by the courts. This means that

revision and clarification (if not recission) of AR 40-3 carries added importance. Court intervention is especially ineffective and unworkable in this area, as reflected in the number of reported cases in which the patients have died before the court heard the case. Rhoden notes that "[j]udicial decisionmaking is cumbersome, intrusive, and extremely time-consuming, often resulting in appellate decisions long after the patient is dead."²⁹² In addition, courts end up tinkering with nuances and inferences contained in regulations, clogging the courts with legislative concerns and invading the province of those with constitutional responsibility for making such determinations.

There is simply no need to "constitutionalize" this area of the law. The Supreme Court should seize the opportunity Cruzan presents to repudiate the doctrine of constitutional privacy. It has the opportunity in Cruzan to reverse the cluster of privacy cases that began with Griswold and saw their apex in Roe v. Wade. These cases constitute anomalous constitutional interpretation. There is no support for such a right in the language of the Constitution, which even its adherents acknowledged as recently as last summer. In his Webster dissent, Justice Blackmun said that the right to privacy, like "the 'critical elements' of countless Constitutional doctrines appears nowhere in the Constitution's text."²⁹³ Professor Rubenfeld admits that, "[a]t the heart of the right to privacy, there has always been a conceptual vacuum."²⁹⁴ While he would solve this by a forthright acknowledgment that justices must incorporate sociology and other concepts into legal analysis, it is better solved by a return to the text of the Constitution itself.

John Hart Ely supports abortion but repudiates Roe and the privacy cases. Through these cases, he argues, the Court usurped the power of the legislatures and conferred on itself a "mandate to second-guess legislative balances."²⁹⁵ Ely agrees that some rights, such as the right to travel, are not explicitly mentioned in the Constitution but that they are

clear from the Framers' intent and the kind of government they contemplated.²⁹⁶ Reliance on a rootless, "general right to privacy," however, means the Court can implement it "when it suits its purposes by referring to the shadowy, manipulable penumbras of the Bill of Rights that "can have no content independent of a description of some general value or values inferable from the provisions involved."²⁹⁷ Judge Robert Bork writes that Griswold was "insignificant in itself but momentous for the future of constitutional law."²⁹⁸ The former jurist said "the 'right of privacy' has become a loose canon in the law," because it "will turn out to protect those activities that enough Justices to form a majority think ought to be protected," becoming "nothing more than a warrant judges had created for themselves to do whatever they wished."²⁹⁹

In Cruzan, the Court can reject a patient's right to withdraw food and water by honestly following the method of analysis it has constructed for cases involving the evaluation of fundamental rights. If it searches for whether the right to withdraw food and water is "inherent in our concept of ordered liberty" or "deeply rooted," it will have to find that it is not. Such a right received no recognition until the past 10 to 15 years, so its roots are shallow.³⁰⁰

The fact that the highest courts of many states have found such a right does not make its roots any broader or deeper. Such courts based their decisions on widely different bases, using divergent tests and evidentiary standards; most importantly, they are the decisions of the courts not of legislatures. Legislatures have been either silent or explicit in excluding the withholding of food and water from the kind of care that can be withdrawn under their living will statutes. This undercuts, or at least muddies, any assertion of near unanimity on the part of the states. The number of state high court holdings argues, if anything, in favor of a federalistic, pluralistic system, not for transforming the right to die into a constitutional right. The Supreme Court is nothing but a super-legislature at its most brazen when it assesses

constitutional protection based on its reading of state courts, polls, and interest group position papers.

The law cannot afford the fruits of a doctrine such as the right of privacy. It yields not only socially divisive opinions such as Roe v. Wade, but it loosens the underpinnings of our federalistic system by arrogating onto the courts the authority to impose their beliefs on the populace under the cloak of the nonspecific, ill-defined right of privacy.

IX. CURBING the RIGHT of PRIVACY: RETURNING the DECISION to the STATES (and to the MILITARY)

Should the Court reject any constitutional dimension of a right to die in Cruzan, the case could stand for more than that proposition. It could signify the end of what appeared to be a slide to constant expansion of the constitutional right of privacy. The Court seemed to recognize this danger in Bowers when, for the first time since the Warren era, it said it would not continuously expand a right.³⁰¹ Such a decision would help return the Court to its role as interpreter of the Constitution. Rubenfeld fears that if the Court remains as text-bound in future cases, this "could portend dark days for the privacy doctrine."³⁰² This would redress the imbalance in our federalistic system that Justice White said the privacy line of cases fostered: "The Court is most vulnerable and comes nearest to illegitimacy when it deals with judge-made constitutional law having little or no cognizable roots in the language or design of the Constitution."³⁰³ Robert Destro argued that this dynamic of ever-expanding Constitutional rights stems from "the assumption that judicial authority can substitute for legislative action...deemed by the litigants or the court to be inadequate or archaic in light of the perceived current needs of the legal system. ...Such reasoning has the potential to erode even further the Constitutional doctrine of separation of powers and federalism."³⁰⁴

In Webster, several justices hinted that Roe, and thereby

the right of privacy on which it rests, was ripe for overturning. Justice Rehnquist, citing, inter alia, Solorio v. United States³⁰⁵ (in which the Court overturned its 18 year-old requirement of establishing "service connection" before trials by court-martial), wrote: "We have not refrained from reconsideration of a prior construction of the Constitution that has proved 'unsound in principle and unworkable in practice.'"³⁰⁶ The dissatisfaction expressed by Justice White, combined with "[t]he changing membership of the High Court raises the possibility of a wholesale reconsideration of the privacy doctrine's propriety."³⁰⁷

Justice Brennan argued in dissent for a "true jurisprudential debate" about whether the Constitution includes an 'unenumerated' general right to privacy," while insisting that "the fundamental constitutional right[,] for which [Roe] was developed is the right to privacy," but the Court majority appears to have grown weary of even arguing the point."³⁰⁸ The Chief Justice countered that drawing fine distinctions between degrees of constitutional protection has only spawned more litigation and more uncertainty: "[T]here is wisdom in not unnecessarily attempting to elaborate the abstract differences between a 'fundamental right,'...a 'limited fundamental constitutional right,'...or a liberty interest protected by the Due Process Clause."³⁰⁹ Justice Scalia concurred that "[t]he Court has often spoken more broadly than needed in...announcing a new rule of constitutional law."³¹⁰ The Court majority seems to acknowledge that Griswold begat Eisenstadt, which begat Roe, which begat Colautti, Belotti, Danforth, Akron, Ashcroft and Webster, not to mention Quinlan and the right to die cases.

And of course Webster triggered activity in nearly all state legislatures, meaning that the state of abortion law will remain unsettled for some time, but that the decisions will be made at the constitutionally appropriate level. The Army needs to be prepared for similar post-Cruzan activity, because a ruling with a similarly federalistic grounding will leave the regulation of the right to die to the states and, therefore,

to the Federal Government as rule-maker for the military. While the Jobes court assumed that "disagreements [about whether to stop feeding a patient] will be rare and that [court] intervention seldom will be necessary,"³¹¹ federal courts would have to handle disputes involving military hospitals. To avoid having federal judges determine military policy in this area, the military must be prepared to implement specific and detailed regulations that will minimize the need for recourse to the federal courts. The less clear the regulation, the greater the invitation to the federal courts to put their own gloss on the regulation. A clean, unambiguous regulation will deter them. As the Court said in Rutherford, "Under our constitutional framework, federal courts do not sit as councils of revision, empowered to rewrite legislation in accordance with their own conceptions of public policy."³¹² Even courts that have ruled in favor of the right to die have expressed a preference that such matters be left to the legislature, because "it has the resources and ability to synthesize vast quantities of data and opinions."³¹³ Anything less than clarity in a regulation, however, will beckon courts to intervene.

Determining who should die (or, couched most dispassionately, monitoring those who make that decision) simply is not a job for the courts. To the extent that judgments ever have to be made about the degree of protection society affords the sick and handicapped, those are peculiarly legislative judgments. The Supreme Court held in Cleburne that treatment of the "mentally retarded" is "very much a task for legislators guided by qualified professionals and not by the perhaps ill-informed opinions of the judiciary."³¹⁴ The path from Roe to Webster is littered with constitutional fits and starts, from courts attempting to fashion a jurisprudence in an area that should be left to those accountable to the electorate. Simply, "courts do not substitute their social...beliefs for the judgments of legislative bodies."³¹⁵ The principle of separation of powers loses its theoretical fuzziness when applied to this area. "[N]either the judges nor

the self-appointed 'ethical experts' are constitutionally adequate substitutes for the elected representatives of the people themselves."³¹⁶ Destro emphasized that society must decide "whether the ultimate aim of medical treatment is always to cure or rehabilitate...in the only forum designed for such debate -- the legislature."³¹⁷ Ellman, sympathetic to the right to die, nonetheless believes that "terrible injustice may result [from]...legal fictions that allow the Court to avoid confronting the hard choice before it," and that, though some "hard cases" like Nancy Cruzan's might appear to force a sick person to live, "[i]t would be an even greater error to constitutionalize the masquerade."³¹⁸

X. "QUALITY of LIFE," the SLIPPERY SLOPE and EUTHANASIA

A. Rights Beget More Rights

It is no longer a matter of not creating a new right, such as the right to withdrawal of food and water to avoid the slippery slope; society, medicine, and the law have been sliding down it for some time. The leap from Griswold to Roe to Quinlan takes on the pattern of the orderly march of constitutional interpretation, instead of unwarranted extrapolation from words that do not appear in the Constitution. Judge Compton's concurrence in Bouvia illustrates how seeds are sown for future decisions. The twin ethics of medicine and the law combine to foster an atmosphere in which shock gives way to resignation and acceptance -- and then opens the door to more shocks.

The ever-expanding dynamic of rights is evident in both law and medicine. As Destro observed, "[t]oday's implicit assumptions drive tomorrow's decisions on the same or similar topics,"³¹⁹ and today's assumptions have become that a person's life is measured by the extent to which he can enjoy it and contribute to society. His personhood is tied to his functionality.³²⁰ Just as the law helped abortion evolve from

an aberration to the social norm, so has the option of starving patients to death, and so will sparing them the pain, time and costs of starvation by speeding their "choice" to die with the option of lethal injection. Former Surgeon General C. Everett Koop writes that the sanctioned withdrawal of food and water "could never have come about had it not been for abortion"³²¹ and the social and medical respectability that it -- and its underlying ethic -- gained from the votes of seven men in 1973. Judge Compton proposed the idea of direct euthanasia in Bouvia, and Hector Rodas petitioned a Colorado court to allow him to die by injection, making clear that it will be the next issue courts confront, since it builds logically on the denial of food and water. A recent survey of Colorado physicians found that 60% had treated patients for whom active euthanasia should have been an option, and 59% would have been willing to administer a lethal drug if legal, a practice no longer uncommon in the Netherlands.³²² Twenty years ago a California medical journal envisioned this "progress" when it suggested an ethic that valued human lives for their functionality. It said "[m]edicine's role with respect to changing attitudes toward abortion will be a prototype" as "problems of birth control and birth selection are extended, inevitably, to death selection and death control...and further public and professional determination of when and when not to use scarce resources."³²³

B. Finite Medical Resources

The concern for shrinking medical resources applies to the military as well to civilian society,³²⁴ and could only become more acute in an era of curtailed military budgets. In 1989 the Brooke Army Medical Center in San Antonio, Texas, began to refer large numbers of patients to civilian health care facilities because of an overburdened staff that included nurses required to work 12 hour shifts because of personnel shortages.³²⁵ This has three important implications for the

military: 1) it could encourage pressure to withdraw food and water in light of the limited amount of care available, 2) it could affect the perspective of hospital personnel on ethics committees, and 3) it illustrates the likelihood of patients' being subject to different laws regarding withdrawal of food and water, depending on whether they are treated in civilian (or other federal) facilities. For example, were Texas to forbid withdrawing food and water, a patient could gain the protection of Texas law (or lose the choice offered by the Army) upon his chance transfer from Brooke, at which federal law or the Army regulation would apply. Army policy states that Army patients treated as sister services' hospitals will receive medical care "in accordance with the instructions of the military service providing the care."³²⁶

As elsewhere, not all considerations are purely legal ones. Dr. Koop quotes a British professor as suggesting that it is the arrogant, pampered healthy who view limitations on medical resources -- and the burdens imposed by PVS patients -- with alarm. "[I]t can be argued that if selection is practised, it may not be necessarily the fittest on whom the greatest effort should be expended."³²⁷

C. Reconsider Value of Life

Peter Singer echoed California Medicine's view that society cannot be held back by archaic concepts of the inherent value of each human life:

The ethical outlook that holds human life to be sacrosanct -- I shall call it the quality of life ethic -- is under attack. The first major blow was the spreading acceptance of abortion, and that we can no longer base our ethics on the idea that human beings are a special form of creation. ...[W]e would not regard as sacrosanct the life of each and every member of our species, no matter how limited its capacity for intelligent or even conscious life may be."³²⁸

The Roe majority presaged Singer's viewpoint, albeit more felicitously, in holding that a fetus must be capable of "meaningful life" outside the womb before the state was permitted to protect it.³²⁹ Professor Ely foresaw the current controversy when he wrote that "most of the factors enumerated [by the Roe majority] also apply to the inconvenience of having an unwanted two year-old or a senile parent around."³³⁰

So long as life's coming into existence, maintenance, and termination all hinge on a set of factors that any clever judge, physician or "ethicist" can contrive, the focus is the worth of the individual as judged externally. And so long as this is true, human life loses any inherent basis for its protection, and the law loses its reliability and moral underpinnings. While philosophers seek fine distinctions over whether there is a difference between "active" (administering a lethal drug, shooting) and "passive" (starvation, dehydration) euthanasia, the result is no different. Starving PVS patients is especially selective and cruel, given that they are not the only patients incapable of feeding themselves. The Brophy trial court found "approximately 42% of the patients at the hospital were unable to feed themselves and required some form of artificial feeding."³³¹ The distinguishing factor in the eyes of right-to-die advocates, then, is not that patients need help to eat, but the bleakness of their prognoses. All of these cases rely on the underlying fiction that when food and water are withdrawn from an otherwise sick, "defective" or even terminally patient who then dies, it is the underlying condition and not starvation that causes the death. This begs the obvious question: but for withdrawal of nutrition, the person would continue to live. This makes a patient's dependency on others grounds for withdrawal of care, abetted by the ethic that says, in effect, that if you can't feed yourself [and we're not sure your life is (old person) or will be (newborn) worth living], you don't deserve to live. "It is

not the disease or disability which kills the patient but an act or omission done with the specific intent of bringing about the death of a disabled individual."³³²

D. The Case for Humane Lethal Injections

The "slippery slope," then is nothing more than the legal process at work over the course of a generation, demonstrating that "without a clear anchor in first principle, the law can rapidly progress to the point where unacceptable behavior is sanctioned."³³³ Once a judge, relying on an expert, confers on a principle the sanction of law, it becomes precedent not only for that principle but for extensions of the underlying reasoning. The President's Commission acknowledged its concern with such thinking in stating that acceptance of the slippery slope argument might result in "the continued prohibition of some conduct which is actually acceptable."³³⁴

Lethal injection, then, seems a humane and speedy alternative to starvation or dehydration. And, of course, this is the hope of those who greased the slope. Its advocates, once out of the mainstream, now appear reasonable.³³⁵ Professor Destro observes: "The principle of evaluating life based on its quality rather than its nature, once accepted, will inexorably lead to extensions of the rationale as the cases get harder and death appears to be most humane under the circumstances."³³⁶ Though the functional, quality of life judgments have reached their most extreme, because they now involve decisions by others about death, they are not novel. In 1927, Justice Oliver Wendell Holmes, wrote that "three generations of imbeciles are enough" in permitting the state to involuntarily sterilize a woman in a mental institution.³³⁷ Justice Anderson of the Washington Supreme Court, who supported the withdrawal of Barbara Grant's respirator but called "withholding intravenous nutrition and hydration...to let her die of thirst or starvation...pure, unadorned euthanasia," wrote in 1987 of the evolution of thinking in this area:

As recently as five years ago, or perhaps three, the idea that fluids and nutriment might be withdrawn, with...legal impunity, from dying patients...would have been repudiated, if not condemned... The notion would have gone "against the stream" of medical standards of care. [However,]...this practice is receiving increased support from both physicians and bioethicists. This new stream of emerging opinion is typically couched in the language of caution and compassion. But the underlying analysis, once laid bare, suggests what is truly at stake: That for an increasing number of patients the benefits of continued life are perceived as insufficient...[and] that death is the desired outcome.³³⁸

E. Duty to Die; Formulas for Evaluating Life,
Redefining Death

Flowing from the delicately-cloaked option of euthanasia becomes the duty to die. Colorado governor Richard Lamm stirred a controversy in 1984 when he said that the elderly with terminal illnesses "have a duty to die and get out of the way, instead of prolonging their lives through artificial means."³³⁹ So long as some have a duty to die, others, unable to independently exercise that duty could have it exercised for them -- via substituted judgment, best interests or a new judicial test. Of course, criteria will be needed on which to hinge those decisions, but society does not lack for those with inventive approaches.

Some suggest redefining death so that a "higher brain" or "neocortical" concept of brain death would allow some patients, especially the persistently vegetative, to be declared dead sooner, liberating medical resources, reducing medical bills and dropping insurance and tax rates for the still-living. Daniel Wikler says that if "the definition of death...can be expanded to include the persistently vegetative state," then

the whole controversy over withdrawal of care would be moot.³⁴⁰ He seeks "a substantial adjustment in our thinking about death, one that changes the focus from biological to psychological processes."³⁴¹ Daniel Callahan proposes an age-based standard for determining how much cost and effort society should bear in keeping an old person alive.³⁴² Another article suggests plugging a PVS or terminally ill patient into the following formula in deciding whether to let him eat and live or starve and die: $QL = NE \times (H + S)$ where QL =quality of life, NE =natural (physical and mental) endowment, H =contribution of home and family and S =the contribution from society.³⁴³

At the beginning of life, some suggest that redefining life -- or postponing the conferral of personhood -- would generate the flexibility needed to determine whether handicapped newborns should be fed. Nobel Prize winning scientist James Watson said, "If a child were not declared alive until 3 days after birth...the doctor could allow the child to die if the parents so choose and save a lot of misery and suffering."³⁴⁴ His colleague, biologist Francis Crick concurred: "No newborn infant should be declared human until it has passed certain tests regarding its genetic endowment, and if it fails these tests, it forfeits the right to live."³⁴⁵ Such proposals seem cold and utilitarian, but only because most others are "insufficiently brave to simply state that the incompetent patient is just not fit to live."³⁴⁶ The first time a group of Americans had the chance to accept active euthanasia, they demurred, however. A 1988 California ballot initiative to permit active euthanasia failed to receive the required number of signatures to appear on the general election ballot.³⁴⁷

Finally, there are even implications for the criminal law. In 1989, a Maine probate judge denied a request by Mark Pagan to continue the tube feeding of the comatose man he had stabbed -- and for whose murder he was likely to stand trial after the man died. Pagan already had served a three year term for aggravated assault for the 1985 attack.³⁴⁸

F. Harvesting Anencephalics: Redefining Death
and its Implications for PVS Patients

As the quality of life ethic expands, it seeks not only to redefine death and to permit lethal injections to bridge the period between starvation and death, but also to encourage harvesting the organs of the near-dead (or handicapped or burdensome) to serve the near-healthy who, but for a fresh organ, could live "meaningful" lives. Proposals abound for amending the Uniform Determination of Death Act's (UDDA) definition of death, currently the "total and irreversible cessation of all brain activity," to define anencephalic newborns as dead, and to amend the Anatomical Gift Act to permit removal of organs from anencephalics. (Anencephalic newborns are babies born with nearly all their brains missing. They usually live no more than one week. Because they usually have no other organic anomalies, their organs and tissue are considered ideal for transplantation.)³⁴⁹ If, however, they are allowed to live their short lives without intensive care or maintenance, their organs become unsuitable for transplantation.³⁵⁰ Dr. D. Alan Shewmon explains that if doctors wait for a reliable diagnosis of death, as currently defined, "their organs are useless."³⁵¹ Therefore, some seek to declare them dead at birth, which would make their organs immediately available, or to provide for their maintenance on machines, so that their organs would remain of transplantable quality for the maximum period of time. Typical of the proposals is that offered by a California state senator to amend the UDDA to state that "an individual born with the condition of anencephaly is dead."³⁵² There are many problems with such a proposal, among them that the (usually prenatal) diagnosis of anencephaly "opens the door to manipulation."³⁵³ It is, however, consistent with the philosophy that values humans only for their contributions to society.

Another aspect of the issue concerns artificial maintenance of the anencephalic (dead, according to the California

proposal) until his parts are needed. George Annas argues that the law should find a way "to maintain these infants for organ donation" so long as we can "safeguard them from harm as we try to turn their plight (and their bodies) to the benefit of others."³⁵⁴ In 1989 the Ohio legislature considered a bill that would permit "donating the organs of [live] anencephalic infants for transplantation" and, with parental consent, keep infants on life support up to 10 days to obtain "any part of the infant's body" for transplant.³⁵⁵ The cases of children with Downs' syndrome who have been allowed to die without food and water or elementary corrective surgery illustrate more strikingly how those with relatively minor, correctable "defects" are pushed aside by the more fully functional humans.³⁵⁶

Such proposals, then, are hinged to the definition of personhood that lies at the heart of the struggle over PVS patients, with whom the anencephalics have much in common. As Drs. Willke and Andrusko explain, a PVS patient is "functionally no different from an anencephalic newborn. ...If persons in a persistently vegetative state have no consciousness, no capacity to think and are going to die anyway, why should they not be 'allowed' to 'donate' their organs?"³⁵⁷ One Loma Linda research scientist found some solace in the fact that tissue used in experiments came from anencephalics instead of monkeys. "Not only does the [anencephalic] have human genes, but it is a nonperson and sure to die, whereas the monkeys are living and, well, there's a down side to that."³⁵⁸

Young, critically wounded soldiers are another prime source of healthy, transplantable organs. Army policy currently forbids "transfer of fatally ill patients to the Army Organ Transplant Center as potential cadaver organ or tissue donors,"³⁵⁹ but recognition of the right to die can lead to suggestions that soldiers be allowed to make "one final contribution to society" through the harvesting of their organs or keeping them on life support until a needy recipient can be

located.

XI. UNIQUE PROBLEMS for the MILITARY

Carefully or uniformly implementing the right to die in the military would be a logistical nightmare that would not serve those who want to make advance directives about their death -- either in prescribing when care will be withdrawn or in stipulating continued care.

A. Population, Mission

The question of withdrawing food and water carries unique implications for the military health care system, because of the military's peculiar demographics and its missions. The military is disproportionately populated by young people involved in dangerous work. Even in a training environment head injuries are prevalent. In war time, soldiers will jump from aircraft, ride in tanks and receive fire.³⁶⁰ The resulting head injuries, coupled with high quality intensive medical care, make likely the survival of many mentally disabled personnel, some of them in vegetative states. The military also provides health care to retired members and their qualified dependents, meaning that it treats many old people who are likely to suffer the kind of illnesses, such as strokes, that trigger the PVS condition. Because the Army provides legal services to this same population, it faces the challenge of advising these beneficiaries accurately and serving their needs, anticipating the many variables (including war and being stationed in states or countries other than where a living will might be written) tied to military life.

The substituted judgment methodology is especially inapt for such a population. As the Cruzan court acknowledged, a young person's life is far too precious to be discontinued based on remarks made to others. Most young people do not seriously contemplate death and, once vegetative, should not

be captives of flip remarks such as Paul Brophy's about "punching a ticket" or those of young Joseph Gardner that the Maine Supreme Court found sufficient on which to base a decision to stop feeding him. The military uniquely offers young people the opportunities of danger, adventure, serious injury and death -- and the wise-cracking cynicism such opportunities generate. An airplane hanger before a parachute jump, a troop ship, or any of many combat or dangerous training settings provide fertile ground for statements about death. Physicians, courts and ethics panels should not have to (and are not equipped to) separate the gallows humor and bravado from what Maine discerned was the "solemnity" of 23 year-old Joseph Gardner's statements about death. To allow otherwise invites decisionmakers to manipulate the statements made by PVS patients to achieve desired results.

B. Fast-Changing Area, Remote Stationing

Legal assistance attorneys, frequently in their first post-law school jobs, write living wills for soldiers from all over the United States, usually relying on handbooks and unofficial supplementary information in one of the more rapidly changing areas of the law.³⁶¹ Once it is time to enforce a living will, a host of almost capricious factors arises. Foremost is determining how to enforce a will written for another jurisdiction, or trying to enforce one overseas, a problem not only because a large share of our forces remain stationed on foreign soil, but also in the event of war, when triage decisions are made hastily.³⁶² Most soldiers are away from home, and a high percentage are young and single.

This means, then, that most of them, like the rest of the population, will not have living wills, but also that they are geographically far from those whose "substituted judgment" might inform medical personnel about the course of their treatment. Any novel approach such as the family-based decision making urged by Rhoden and others, and endorsed as far back as

Quinlan³⁶³ is particularly unworkable for military members. The scramble to determine a sick soldier's fate in such circumstances would require either the involvement of decision-makers such as the loosely-constituted ethics panels, or the heavy intervention of the federal courts. While the sheer persistence of the vegetative state might suggest that decisions need not be made quickly, the decision whether to even initiate tube feeding will take on increasing importance if the Court decides there is no constitutional right to withdraw it. Military health care professionals must know in advance how to handle such patients, including how and whether to honor a soldier's "living will." Should a soldier have a living will that directs that food and water be discontinued if he becomes vegetative, the military would have to decide whether to follow the directive, in light of, inter alia, its commitment to return soldiers to duty.³⁶⁴

C. The Services Diverge

The three military services have different policies. The Army's policy, despite its ambiguities, is the most explicit, permitting termination of care under some conditions. The Air Force has the dated, Quinlan-based policy; the Navy has none at all. The disparity among the states offers little help in determining how to solve conflicts among the three. Only six of the 41 jurisdictions with living will statutes expressly honor living wills drafted in accordance with other states' laws.³⁶⁵ Regardless, the nascent and developing state of the law in this area means that a living will, standing alone, offers little certainty or predictability, particularly to a soldier. It is not a fanciful scenario for the military to have to grapple with how to administer the living will of a soldier from the 7th Infantry Division (Light) whose Kansas living will was witnessed by an Army JAG at Fort Ord, California, before the Kansan deployed to Panama, and who is now being treated at an Air Force medical center in Texas.

Further complicate the scenario by treating the soldier in Europe, Korea or the Philippines, perhaps at a Navy facility at which there are no rules at all. Then the soldier's family files suit charging that the sick soldier is being denied equal protection because his similarly-situated comrades were allowed to die in Army medical centers.

And how can all of the information necessary for making such decisions to be communicated to the remote decisionmakers in Texas -- or Germany, The United Kingdom or the Sinai?³⁶⁶ Regulations will have to be drawn to determine what information will be communicated to the decision-makers so that their decisions can qualify as legally "informed." To what extent can such considerations be factored into the critical triage decisions that are made not only on the battlefield but at every early level that care is administered?³⁶⁷ And, so long as shrinking medical resources are an issue in the civilian medical world, to what extent will the military establishment, buttressed by language in AR 40-3, steer decision-makers into decisions to withdraw food and water?

Therefore, uniformity for its own sake is an important goal. The problem arises with regard to Army soldiers, governed by AR 40-3 and the HQDA Letter, transferred to or treated in facilities run by sister services, or other federal facilities, or state-run medical centers. Each type of facility may apply different standards with regard to withdrawal of food and water. While the Army gives some direction for treatment of its patients in non-military federal facilities and state institutions, those provisions are not as specific as those allowing the Air Force and Navy to treat soldiers in accordance with their regulations.³⁶⁸ This highlights the need for uniformity among the services. In the absence of such uniformity, especially after the Supreme Court rules in Cruzan, federal courts will not be able to resist the temptation to intervene. And so long as military medical needs require the transfer of patients between the services and into the civilian community, they will not lack for opportunities

to do so.

D. Conscience Exception

Military health care providers need the freedom to exercise their moral choices not to participate in withdrawing food and water when their consciences keep them from doing so. The regulation covering abortions provides such an exception.³⁶⁹ AR 40-3 needs similar language to protect physicians and nurses from even passive participation in decisions to withhold or withdraw food and water. The language must be specific and unequivocal, given courts' tendencies to treat the right to die as absolute and their inclination to find that medical personnel have a "duty" to help execute the decision, including referral of patients to hospitals that will deny treatment that the host hospital insists on providing. The Gray court ruled that Rhode Island's conscience exception for abortion did not apply to withdrawal of food and water, and that the Rhode Island Medical Center had to "accede to her [Mrs. Gray's] request" to receive no food and water or transfer her "to a health care facility that will respect her wishes."³⁷⁰ New Jersey gave the Lincoln Park Nursing Home the same choice: stop feeding Nancy Ellen Jobes or move her to a facility that will.³⁷¹ The Massachusetts court, while recognizing a right to die, said that it would "decline to force the hospital to participate" in effecting a patient's decision to withdraw a feeding tube so long as it transferred him to a facility that would do so.³⁷² The Grant court also tried to appear Solomonic, holding that "[n]o health care provider should be required to participate" in starving a patient but that they could not "interfere with the transfer of a patient to another health care provider...."³⁷³ Such rulings require doctors, nurses and hospitals to violate their consciences by becoming passive parties to the withdrawal of food and water.

The debate continues in medical journals. Two health professionals wrote that hospitals "may indeed be capable of

having moral objections to treatment decisions" and that

if a patient wished to refuse a course of treatment that was not leading to any meaningful recovery in order to end his or her life, we would hope that the hospitals would have moral objections. ...[T]he purpose of hospitals is [not] to be comfortable places to die for those patients who refuse the care they have to offer. ...Hospitals reflect the ethical traditions of the health care profession.³⁷⁴

The Army gives the appearance of institutional indifference to life and to those whose consciences might make them uncomfortable executing a decision to withdraw food and water when it allows popular cadence calls or "Jodies," that make light of human "vegetables."³⁷⁵ Too much can be made of such antics, but the institution would not tolerate comparable lyrics regarding minorities or women.

XII. SOLUTION

A. Require Provision of Food and Water

Food and water, no matter how delivered, are different in kind from any other care (or "treatment"):

Food and water, whether administered by mouth or by other means, perform the same function for the able-bodied as... for the disabled: they are the basic essentials of life. Thus, the test is not whether the substance administered will "cure" the patient, but rather the function it performs and whether that function is identical in both cases.³⁷⁶

A clear and simple exception needs to be made so that patients in military hospitals receive them under all circumstances. The Army should change AR 40-3 to read: "Food and water, regardless of how they are provided, shall not be withheld or withdrawn from any patient at any time. Any oral

or written directives from a patient, his family or others asserting rights on his behalf, shall be of no effect in administering nutrition and hydration." This is simply a matter of revising AR 40-3 (or, ideally, writing a DoD-wide policy) along the lines of the state laws that exclude food and water from the kinds of treatment that can be withdrawn pursuant to a living will. For example, Wisconsin allows patients to direct the withholding of "life-sustaining procedures," but stipulates that such procedures "do not include...[t]he provision of fluid maintenance and nutritional support."³⁷⁷ South Carolina accomplishes the same purpose in two steps. It allows withdrawal of all procedures except "nutrition, and hydration for comfort care."³⁷⁸ Then, its living will declaration, the form for which appears in the statute, allows patients to direct that any treatment or procedures be withheld except those "necessary to provide me with comfort care."³⁷⁹

The same purpose could be accomplished by Congress' passing a law making this the policy for all federal hospitals.³⁸⁰ It could copy the Missouri statute upheld in Webster, which made it "unlawful for any public employee within the scope of his employment to perform or assist an abortion, not necessary to save the life of the mother" and "unlawful for any public facility to be used for the purpose of performing or assisting an abortion not necessary to save the life of the mother."³⁸¹ This would be no different than the one-sentence Hyde Amendment which forbade use of federal funds to pay for abortions. The Supreme Court upheld this congressional exercise of the spending power in Harris v. McRae, on the grounds that even if a woman had a right to abortion, she had no right to require the federal government to provide her with one.³⁸² Alternatively, the Department of Defense could issue a directive requiring all of the services to implement such regulations. This would lack the force of a federal law, but would bind all of the uniformed services and bring them into conformity with each other.

B. Otherwise, Tighten the Regulation

The Army leads the other services in that it has a written policy, albeit one cluttered with ambiguities, that at least begins to address the issue. It should borrow from the states to eliminate ambiguities in the current regulation.

1. Presume in Favor of Care

So long as the Army is going to permit food and water to be withdrawn, it should narrow the circumstances in which it is allowed, and erect a strong presumption in favor of feeding PVS patients. It can borrow from Oklahoma. In 1987, Oklahoma passed a statute that presumes "every incompetent patient has directed his health care providers to provide him with hydration and nutrition to a degree that is sufficient to sustain life."³⁸³ However, the presumption does not apply when there is "clear and convincing" evidence that the patient decided against it when competent, the measures will cause "severe, intractable and long lasting pain" or the "incompetent patient is chronically and irreversibly incompetent" and "death is imminent."³⁸⁴ The statute leaves room for abuse or manipulation, but is much more specific than AR 40-3, especially with the initial presumption of continued nourishment, and the requirement in every case of imminent death before care can be withdrawn. The Army should not adopt the further limitation of the Oklahoma statute that says "[hydration] or nutrition may not be withheld or withdrawn...if this would result in death from dehydration or starvation rather than from the underlying illness or injury."³⁸⁵ Such conclusions about the cause of death are subject to semantic manipulation or philosophical obfuscation. So long as physicians and philosophers disagree, the law cannot impose certainty in this area; better to leave an unqualified presumption intact.

2. Decisionmaking Hierarchy

Physicians and patients need a precise, workable hierarchy for implementing the decision to stop providing artificial nutrition and hydration. The term "next of kin," should be clarified to specifically delineate (like the Arkansas statute cited above) the order of individuals to be consulted before a decision is made about whether to continue feeding a patient.

3. Informed Consent

The Army should print plain-English disclosures which make clear the patient's absolute right to continued treatment. Additionally, the physicians should explain in writing the prognosis for the patient's particular condition or disease. This process may seem bureaucratic, time-consuming and self-protective; it should be all of those things. The Supreme Court required the Miranda warnings to ensure that criminal suspects knew their constitutional rights before exercising or waiving them.³⁸⁶ So long as patients have a right to die from withdrawal of food and fluids -- and especially so long as third parties may exercise this right on their behalf -- the circumstances call for regulations and warnings just as strict as for criminal suspects.³⁸⁷ Should the "constitutionalize" this area, the opportunities for meaningful informed consent would diminish. Because of abortion's exalted status, the Court repeatedly has found states' informed consent provisions to unconstitutionally burden women's decisions whether to have abortions.³⁸⁸

4. Define "Terminal"

The revised regulation should define terms such as "terminal illness" with sufficient specificity that physicians

and families (and ethics panels) do not have to grapple with them during times of turmoil. Again, Wisconsin offers some clarity, defining a terminal condition as "an incurable condition...that reasonable medical judgment finds would cause death imminently, so that application of life-sustaining procedures serves only to postpone the moment of death."³⁸⁹ No definition is ideal, but this one is more specific than, for example, Montana's which defines a terminal condition as one that will "result in death within a relatively short time."³⁹⁰

5. Conscience Exception

The regulation should protect the consciences of those who object to participating in decisions to withdraw food and water. This provision should be broader than the abortion provision because it should also make explicit that such objections do not disqualify such personnel from sitting on ethics panels. To do otherwise would foster a group-think environment on such committees that would merely ratify decisions to terminate food and water. Again, the Army could borrow from Oklahoma, which stipulates that no person or facility will be required to participate in the treatment or care of an incompetent patient who is "to die as the result of dehydration or starvation."³⁹¹

6. Ethics Panels

The regulation should be expanded to make clear what decisions the panels can make, and to set express guidelines on how to make them. In any case of doubt, the decision should require continued care. "Like juries, these ethics committees will be called on to make life or death choices for others, wrote two critics in arguing that, just as "[j]uries are instructed to make a presumption in favor of innocence...[e]thics committees should make an analogous assumption in favor of life."³⁹²

If the Army continues to employ ethics panels to monitor decisions to withdraw food and water, objecting health care professionals should be permitted access to the committees to voice their concerns. Such committees must be more than ratifying bodies for decisions to cut off care or to shield the real decision-makers from responsibility.

It is difficult to suggest an ideal membership construct for an ethics committee. Experience with them is too limited for any one to be suggested as an ideal -- or for issues of such importance to be left to them until this issue is solved. The regulation should leave minimal discretion to the appointing authority in determining membership. At least, the panels should include both a physician and a nurse, as well as a lawyer; in addition, the same membership should be imposed on panels that consider withdrawal of life support and those considering do-not-resuscitate orders. Such committees face practical impediments, including making their existence known to the distraught they are supposed to serve, and facing the "reality [that committee decisions] are based on our values and emotions in effect at the time of decision."³⁹³ Therefore, the ethics panels, like the courts, cannot avoid issuing value-based decisions. This means that composition of the committee is a weighty decision vested in the personnel-selecting discretion of the hospital commander or the director of clinical services. There is no formula that guarantees balance and perspective.³⁹⁴

The Quinlan court was the first to suggest the use of ethics committees in right-to-die cases. It said the "most appealing" benefit would be that the committee "diffuses the responsibility for making these judgments" about who lives and dies.³⁹⁵ The court implies that such decisions are desirable and need to be made, so long as responsibility for them cannot be pinned on particular individuals. Some of the concerns about the limitations of ethics committees in the civilian world -- that profit-motivated doctors will use them to ration medical care³⁹⁶ or will work hand-in-glove with insurance

companies to deny care when maintenance becomes expensive³⁹⁷ -- are less acute in the military. Nonetheless, military hospitals and the military health care system as a whole face their own financial pressures and do not enjoy unlimited resources. Therefore, regardless of their "values-clarifying" virtues, the military does not need ethics panels to cloak or "diffuse" responsibility for such serious decisions.

C. The Regulation Makes a Statement

By keeping intact such a regulation, the Army fosters a public ethic that prefers disposing of the inconvenient to a social ethic that cares for, even pays for, those who will never return what they receive in either love or taxes. To finesse the definition of treatment or purport to objectively assess the value of another's continued life mires medicine and law -- and the Army -- in making decisions that are not theirs to make. As Dr. Koop has stated, "in medicine, nutrition and fluids are life itself."³⁹⁸ Withholding them can bring about the convenient demise of the socially unproductive and burdensome. "Death then becomes the 'final solution' for those whose disabilities make them -- to borrow a phrase -- useless eaters."³⁹⁹

1. U.S. Const. amend V; amend XIV, sec. 1.
2. In Tune v. Walter Reed Army Hospital, 602 F. Supp. 1452, 1453, n.2 (D.D.C. 1985), the District of Columbia court said that Walter Reed, as a federal institution, did not have to follow the District of Columbia Natural Death Act.
3. Michael H. v. Gerald D., 109 S.Ct. 2333, 2341 (1989) (plurality opinion).
4. United States v. Charters, 829 F.2d 479, 491 (4th Cir. 1987) (footnotes omitted), modified on other grounds, 863 F.2d 302 (4th Cir. 1988).
5. Warren & Brandeis, The Right of Privacy, 4 Harv. L. Rev. 193 (1890). While the article contained the frequently-quoted line, "now the right to life has come to mean the right to enjoy life -- the right to be let alone," (Id. at 193), it focused on issues such as unauthorized use of "instantaneous photographs" in newspapers, the increasingly intrusive nature of the press and the proprietary rights of authors of original manuscripts (Id. at 200-205). The article contains no language or citations that suggest its authors envisioned the use to which their concept of privacy would be put nearly a century later.
6. Olmstead v. United States, 277 U.S. 438, 478 (1928) (Brandeis, J., dissenting). Many cases based on a right of privacy cite Brandeis' article or his Olmstead dissent. See, e.g., Eisenstadt v. Baird, 405 U.S. 438, 453 n.10 (1972); Griswold v. Connecticut, 381 U.S. 479, 494 (1965) (Goldberg, J., concurring).

7. 381 U.S. 479 (1965).
8. 405 U.S. 438 (1972) For details of the case, see text accompanying n.15.
9. See, e.g., Bowers v. Hardwick, 478 U.S. 186 (1986).
10. Griswold, 381 U.S. at 484 (citations omitted).
11. Griswold, 381 U.S. at 484.
12. Griswold, 381 U.S. at 495-496 (Goldberg, J., concurring).
13. Justice Stewart introduced his dissent (recanted in Roe) with a defensive acknowledgement: "I think this is an uncommonly silly law. ...I believe the use of contraceptives in marriage should be left to personal and private choice...." However, he insisted, "we are not asked in this case to say whether we think this law is unwise, or even asinine. We are asked to hold that it violates the United States Constitution. And that I can not do." Griswold, 381 U.S. at 527 (Stewart, J., dissenting).
14. Eisenstadt, 405 U.S. at 453 (emphasis in original).
15. 410 U.S. 113 (1973).
16. See generally Planned Parenthood v. Ashcroft, 463 U.S. 476 (1983); Akron v. Akron Center for Reproductive Health, Inc., 462 U.S. 416 (1983); Colautti v. Franklin, 439 U.S. 379 (1979); Bellotti v. Baird, 428 U.S. 132 (1976); and Planned Parenthood v. Danforth, 428 U.S. 52 (1976), all of which declared that the limiting language in Roe was insufficient to support state attempts to regulate abortions.

17. Roe, 410 U.S. at 152, citing Griswold, 381 U.S. at 484-85.

18. Roe, 410 U.S. at 153. Justice Blackmun's use of sentence construction similar to Eisenstadt is not the only strikingly parallel use of language in the privacy area. Note the similarity between Roe and Eisenstadt: Justice Brennan wrote in Eisenstadt that the right of privacy includes a woman's "decision whether to bear or beget a child" (Eisenstadt, 405 U.S. at 453), and Justice Blackmun wrote in Roe that the fourteenth amendment protects "a woman's decision whether or not to terminate her pregnancy" (Roe, 410 U.S. at 153). Compare also Justice Brennan in Eisenstadt: "If the right to privacy means anything" it protects the contraceptive choices of minors (Eisenstadt, 405 U.S. at 453) and Griswold: "If the right to privacy means anything it...", and Justice Blackmun in Bowers: the Court must "analyze respondent Hardwick's claim in the light of the values that underlie the constitutional right to privacy. If that right means anything it means..." Bowers, 478 U.S. at 199 (Blackmun, J., dissenting). This sentence construction reveals not so much a lack of originality as it does the absence of a legal footing on which to place the newly-crafted right of privacy.

19. Roe, 410 U.S. at 154.

20. Roe, 410 U.S. at 155.

21. Roe, 410 U.S. at 173, (Rehnquist, J., dissenting), citing Williamson v. Lee Optical Co., 348 U.S. 483, 491 (1955).

22. Roe, 410 U.S. at 174.

23. Cruzan v. Harmon 760 S.W.2d. 408 (Mo. 1988) (en banc), cert. granted, 109 S.Ct. 3240 (1989).

24. 431 U.S. 678, 685 (1977) (citations omitted).

25. In the Matter of Karen Quinlan, 355 A.2d 647, 662-63, (N.J. 1976) cert. denied, sub nom. Garger v. United States, 429 U.S. 922 (1976).

26. Quinlan, 355 A.2d at 664, 666.

27. Quinlan, 355 A.2d at 664.

28. Quinlan, 355 A.2d at 655. Joseph Quinlan opposed any efforts to stop feeding his daughter. He was quoted as saying, "Oh no, that is her nourishment," when asked whether he wanted to stop feeding her through a tube. Ramsey, Prolonging Dying: Not Medically Indicated, quoted in Ellman, Cruzan v. Harmon and the Dangerous Claim That Others Can Exercise an Incapacitated Patient's Right to Die, 29 Jurimetrics 389, 390 (1989) [hereinafter Ellman, Cruzan v. Harmon and the Dangerous Claim].

29. Brophy v. New England Sinai Hospital, Inc., 497 N.E.2d at 633. Accord In re Conroy, 486 A.2d 1209, 1219, 1222, 1229 (N.J. 1985); In re L.H.R., 321 S.E.2d 716, 722 (Ga. 1984); Corbett v. D'Alessandro, 487 So.2d 368, 370 (Fla. App. 1986); In re Drabick, 245 Cal. Rptr. 840, 853 n.20 (Cal. App. 1988); In re Colyer, 660 P.2d 738, 741 (Wash. 1983), modified on other grounds, In re Hamlin, 689 P.2d 1372 (1984). Some courts straddle the issue, as Minnesota did in 1984: "The right of an individual to forego life sustaining treatment has been based upon a constitutional right to privacy and/or the common law right to be free from invasion of bodily integrity." In re Torres, 357 N.W.2d 332, 339 (Minn. 1984).

30. Union Pac. Railway Co. v. Botsford, 141 U.S. 250, 251(1891). Among the courts to cite this passage is Conroy, 486 A.2d at 1221.

31. Keeton, Prosser & Keeton on the Law of Torts 190 (1984); See also Schloendorff v. Society of New York Hosp., 105 N.E. 92, 92-93 (N.Y. 1914).

32. Canterbury v. Spence, 464 F.2d 772, 780 (D.C. Cir.), cert. denied, 409 U.S. 1064 (1972) (quoting Schloendorff, 105 N.E. at 93). See also Thornburgh v. Amer. Coll. of Obstetricians & Gynecologists, 476 U.S. 747, 772 (1986).

33. Robert Byrn envisioned the coming debate in 1975, but argued that resort to the right of privacy to bolster a right to withdraw treatment (not including food and water) was not only poor law but unnecessary, because the "same result could have been reached by invocation of the traditional right of an individual to control what shall be done with the body...." Byrn, Compulsory Lifesaving Treatment for the Competent Adult, 44 Fordham L. Rev. 1, 5 (1975).

34. In re Farrell, 529 A.2d 404, 410 (1987).

35. Rasmussen v. Fleming, 741 P.2d 674, 683 (Ariz. 1987) (en banc).

36. Rasmussen, 741 P.2d at 688. Accord Conroy, 486 A.2d at 1222 (citations omitted).

37. Rasmussen, 741 P.2d at 688. Accord In re Hamlin, 689 P.2d 1372 (Wash. 1984); Torres, 357 N.W.2d at 339. It is important to note that Rasmussen is based in part on the Arizona Constitution, as well as the Federal Constitution and a litany of state cases. Rasmussen, 741 P.2d at 682, 681. Florida's intermediate court disregarded its living will statute and ruled in favor of a right to withdraw food and water, also based on a right to privacy it found in its state constitution. In re Guardianship of Browning, 543 So. 2d 238 (Fla. 1989).

38. Tune, 602 F.Supp. at 1455.
39. Tune, 602 F.Supp.at 1456.
40. Tune, 602 F.Supp. at 1454.
41. See, infra, text accompanying n.70.
42. A federal court heard the case involving Hector Rodas' plea to have food and water withheld from him, but ruled that no federal laws were relevant in the area. It based its ruling on Colorado law. *Ross v. Hilltop Rehabilitation Hosp.*, 676 F.Supp. 1528 (1987).
43. Brief Amicus Curiae in support of appellants at 4a, American Academy of Neurology, Cruzan v. Missouri (1989) [hereinafter AAN Amicus Brief].
44. *Winston v. Lee*, 470 U.S. 753 (1985). The Court found it significant that the state had sufficient evidence against Winston without retrieving the bullet, but also considered health risks posed by the surgery and the severity of the intrusion into his "personal privacy and bodily integrity." *Winston*, 470 U.S. at 763-66.
45. The Court found this "offensive to human dignity", *Rochin v. California*, 342 U.S. 165, 174 (1952).
46. *Skinner v. Oklahoma*, 316 U.S. 535 (1942). See also *Schmerber v. California*, 384 U.S. 757, 772 (1966); *Skinner v. Railway Labor Executives' Ass'n*, 109 S.Ct. 1402 (1989).
47. 367 U.S. 497 (1961) (Harlan, J., dissenting).

48. Poe, 367 U.S. at 543.

49. Michael H., 109 S.Ct. at 2341 (quoting Snyder v. Massachusetts, 291 U.S. 97, 105 (1934)).

50. Bowers, 478 U.S. at 192 (quoting Moore v. City of East Cleveland, 431 U.S. 494, 503 (1977) (plurality opinion)).

51. Bowers, supra at 191 (quoting Palko v. Connecticut, 302 U.S. 319, 325 (1937), overruled on other grounds, Duncan v. Louisiana, 391 U.S. 145 (1968)). Among the rights courts have found to be fundamental include the rights to: vote, Bullock v. Carter, 405 U.S. 134 (1972); marry, Loving v. Virginia, 388 U.S. 1 (1967); travel between states, Shapiro v. Thompson, 394 U.S. 618 (1969); procreate, Skinner v. Oklahoma, 316 U.S. 535; and, of course, to abortion, Roe v. Wade, 410 U.S. 113 (1973).

52. Michael H., 109 S. Ct. at 2342.

53. Michael H., 109 S.Ct. at 2341 (emphasis in original).

54. Parham v. J.R., 442 U.S. 584, 602 (1979).

55. Parham, 442 U.S. at 621, n.1 (Stewart, J., concurring). In Parham, the Court sanctioned state voluntary mental commitment rules because appropriate deference was paid to the views of parents and medical professionals.

56. Santosky v. Kramer, 455 U.S. 745, 753 (1982).

57. Santosky, 455 U.S. at 747-48.

58. Cleveland Board of Education v. LaFleur, 414 U.S. 632, 639-40 (1974).

59. Smith v. Organization of Foster Families for Equality & Reform, 431 U.S. 816, 842 (1977) (citations omitted). Accord Meyer v. Nebraska, 262 U.S. 390, 399, 402 (1923); Pierce v. Society of Sisters, 268 U.S. 510, 535 (1925); Wisconsin v. Yoder, 406 U.S. 205, 213, 232 (1972).

60. Roe, 410 U.S. at 138-40.

61. Roe, 410 U.S. at 138-40.

62. Roe, 410 U.S. at 130-32.

63. Roe, 410 U.S. at 174 (Rehnquist, J., dissenting).

64. Roe, 410 U.S. at 174-76 (Rehnquist, J., dissenting).

65. Griswold, 381 U.S. at 536, n.13 (Stewart, J. dissenting).

66. Griswold, 381 U.S. at 536.

67. Bowers, 478 U.S. at 192-93. John Hart Ely criticized this method of jurisprudential analysis in 1973: "It surely does not seem to support the Court's position, unless a record of serious historical and contemporary dispute is somehow thought to generate a Constitutional mandate." Ely, The Wages of Crying Wolf: A Comment on Roe v. Wade, [hereinafter Ely, The Wages of Crying Wolf], 82 Yale L.J. 920, 925 n.42 (1973).

68. See Gray v. Romeo, 697 F. Supp. 580 (D.R.I. 1988); Rasmussen, 741 P.2d 677; In re Gardner, 534 A.2d 947 (Me. 1987); In re Peter by Johanning, 529 A.2d 419 (N.J. 1987); Brophy, 497 N.E.2d 626;

John F. Kennedy Memorial Hospital v. Bludworth, 452 So. 2d 921 (Fla. 1984); Torres, 357 N.W.2d 332; In re L.H.R., 321 S.E.2d 716; In re Hamlin, 689 P.2d 1372; In re Colyer, 660 P.2d 738; In re Storar (Eichner v. Dillon), 420 N.E.2d 64 (N.Y.) cert. denied, 454 U.S. 858 (1981); Quinlan, 355 A.2d 647; Corbett, 487 So. 2d 368; Drabick, 245 Cal. Rptr. 840 (1988); Delio v. Westchester County Medical Center, 516 N.Y.S.2d 677 (1987); Leach v. Akron General Medical Center, 426 N.E.2d 809 (1980); Severns v. Wilmington Center, 425 A.2d 156 (Del.Ch. 1980).

69. Bouvia v. Superior Court, 225 Cal. Rptr. 297, 306 (1986).

70. American Medical Association, "Public Opinion on Health Care Issues - 1986" (1986).

71. N.Y. Times, Dec. 2, 1986, at C-10, col. 2. Time magazine reported recently that 80% of citizens surveyed by Time and CNN said decisions about ending the lives of incompetent terminally ill patients "should be made by their families and doctors rather than lawmakers." Love and Let Die, Time, March 19, 1990, at 62, 64. There are two limitations to the poll: 1) it refers to "terminally ill" patients, which does not include the PVS patients, such as Nancy Cruzan, on whom the cover story focuses, and 2) the "rather than lawmakers" question construction plays on anti-government biases and steers respondents to libertarian answers.

72. Results of this and several other media polls are quoted in Jobes, 529 A.2d at 446, n.11. The Time/CNN poll also found that 57% of Americans surveyed "believe it is all right for doctors" in the cases of terminally ill patients "to go even further and administer lethal injections or provide lethal pills. Time, supra, at 64.

73. Micetich, Steinecker & Thomasma, "An Empirical Study of Physician Attitudes," in Lynn, By No Extraordinary Means: The Choice to Forgo Life-Sustaining Food and Water, 39-43 (1986) [hereinafter Lynn, By No Extraordinary Means].

74. U.S. Congress, Office of Technology Assessment, Life Sustaining Technologies and the Elderly, 311 (1987) [hereinafter OTA Report]. See also NFCPG Newsletter, 4 (Summer 1986) for a resolution by the National Federation of Catholic Physicians Guild that food and water are "modalities of ordinary care owed to all patients."

75. 130 Cong. Rec. S8951-8956 (daily ed. June 29, 1984).

76. Torres, 357 N.W.2d at 341, n.4.

77. American Medical Association Opinion 2.20, Withholding or Withdrawing Life-Prolonging Medical Treatment, Council on Ethical and Judicial Affairs, American Medical Association, Current Opinions, 13 (1989) [hereinafter AMA Opinion].

78. Id.

79. Position of the American Academy of Neurology on Certain Aspects of the Care and Management of the Persistent Vegetative State Patient, 39 Neurology, 125 (Jan. 1989) [hereinafter AAN Opinion].

80. Id. See also Conroy, 486 A.2d at 1225, in which the New Jersey Supreme Court found "a majority of practicing doctors now approve of passive euthanasia."

81. Rombeau & Caldwell, Enteral and Tube Feeding 1-19 (1984).

82. Deitel, Nutrition in Clinical Surgery, 66-72 (1985). See Brophy, 497 N.E.2d at 630-31, for a graphic description of a gastric tube and the feeding process.

83. Major, The Medical Procedures for Providing Food and Water: Indications and Effects, quoted in By No Extraordinary Means, supra, at 51.

84. Statement on the Uniform Rights of the Terminally Ill Act, 16 Origins 223 (Sept. 4, 1986).

85. OTA Report, supra, at 12.

86. OTA Report, supra, at 297.

87. AMA Opinion, supra.

88. AAN Opinion, supra. Accord President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Deciding to Forego Life Sustaining Treatment 190 (March, 1983) [hereinafter President's Commission]; OTA Report, supra, at 275-329.

89. Gray, 697 F. Supp. at 586 (citations omitted).

90. Gray, 697 F. Supp. at 586-87. See also, e.g., McConnell v. Beverly Enterprises-Connecticut, 553 A.2d 596, 603 (Conn. 1989); Rasmussen, 741 P.2d at 684; Gardner, 534 A.2d at 954-55; Peter, 529 A.2d at 427-28; Brophy, 497 N.E.2d at 626; Conroy, 486 A.2d at 1217-18; Bouvia, 225 Cal. Rptr 297 at 300, 303.

91. Lynn & Childress, Must Patients Always Be Given Food and Water?, 13 Hastings Ctr. Rep. 17, 21 (Oct. 1983).

92. McConnell, 553 A.2d at 603 (footnote omitted); Barber v. Superior Court, 195 Cal. Rptr. 484 (1983).

93. AAN Opinion, supra.

94. Id.

95. See, e.g., Wisc. Stat. Ann., sec. 154.01.

96. McConnell, 553 A.2d at 603.

97. McConnell, 553 A.2d at 603, n.12 (citation omitted).

98. Robert A. Destro argues that such word choice is a conscious evasion that permits courts to avoid facing the consequences of what they are permitting: "Words which do have a clear meaning (i.e....'food and water') have either been avoided altogether, or rendered ambiguous by judicial acceptance of a result-oriented, functional human rights ethic (viz: calling hydration 'treatment' in order to avoid the implications of accuracy)." Destro, Quality of Life Ethics and Constitutional Jurisprudence: The Demise of Natural Rights and Equal Protection for the Disabled and Incompetent Patients, 2 Journ. Contemp. Health Law and Policy 71, 99 (1986) [hereinafter, Destro, Quality of Life Ethics].

99. Bopp, Nutrition and Hydration for Patients: The Constitutional Aspects, 4 Issues in Law & Medicine 3, 45 (Summer, 1986). He continued: "If the mode of provision determines whether a procedure is a medical treatment, then 'providing poisons by hypodermic syringe would be a medical treatment while providing these by mouth would be mere killing.'" Id., quoting Barry, Respirators and Assisted Feeding: What is the Difference? (unpublished manuscript).

100. Ellman, Cruzan v. Harmon and the Dangerous Claim, supra, at 400.

101. Surgical Nutrition, 749, 751. See also President's Commission, supra, at 174-75, 181; Plum & Posner, The Diagnosis of Stupor and Coma, 313 (1982) [hereinafter, Plum & Posner, Stupor and Coma].

102. Persistent Vegetative State and the Decision to Withdraw or Withhold Life Support, 263 J.A.M.A.:3, 426, 427 (Jan. 1990) [hereinafter PVS and the Decision to Withdraw].

103. President's Commission, supra, at 175.

104. Dougherty, Rawlinson, et al., Hypoxic-ischemic brain injury and the vegetative state: Clinical and neuropathologic correlation, 31 Neurology 991, 995 (1981).

105. Plum & Posner, Stupor and Coma, supra, 6-8.

106. AAN Opinion, supra, at 125. "Even in young persons [whose chances of recovery are greater]...a conservative criterion for the diagnosis of PVS would be observed unawareness for at least 12 months." PVS and the Decision to Withdraw, supra, at 428.

107. Cranford, The Persistent Vegetative State: The Medical Reality (Getting the Facts Straight), 18 Hastings Ctr. Rep., 27, 31 (Feb./March 1988).

108. Conroy, 486 A.2d at 1228, n.4.

109. In re O'Connor, 534 N.Y.S.2d (1988).

110. 13 MPDLR no. 5, 440, 441 (Sept-Oct 1989).

111. Id. See also N.Y. Times, April 15, 1989 at A15, col. 1.

112. 19 Hastings Ctr. Rep. 4, 14 (July/Aug. 1989). See also Predicting Outcome From Hypoxic-Ischemic Coma, 253 J.A.M.A. 1420, 1422-23 (1985). Hypoxia-ischemia is a condition caused by inadequate delivery of oxygen to the brain, resulting from cardiac or respiratory arrest, or carbon monoxide poisoning or shock. It can be caused by insufficient blood flow to the brain or by the absence of sufficient oxygen in the blood that flows to the brain, and it brings on the vegetative state. For reports of other patients who recovered after PVS diagnoses, see Recovery to Social and Economic Independence From Prolonged Postanoxic Vegetative State, 33 Neurology 372 (1983) (injured graduate student eventually recovered to live independently and work as a receptionist); Recovery of Cognition After Prolonged Vegetative State, 2 Annals Neurol. 167, 168 (1977) (recovery began 17 weeks after injury); Delayed Recovery From Postanoxic Persistent Vegetative State, 14 Annals. Neurol. 152 (1983) (patient began to recover 22 weeks after injury, personality fully returned to normal). An expert told the Brophy trial court that there were only two reported cases of recovery from the persistent vegetative state. Brophy, 497 N.E.2d at 630, n.15.

113. Roe, 410 U.S. at 155 (citations omitted); see also Bowers, 478 U.S. at 189 (citations omitted).

114. The only case to survive such scrutiny was the quarantine of the Japanese on the West Coast during World War II, upheld by a divided Court in Korematsu v. United States, 323 U.S. 214 (1944) reh'g denied, 324 U.S. 885 (1945).

115. Skinner v. Oklahoma, 316 U.S. at 540-41.

116. See, e.g., DeFunis v. Odegaard, 416 U.S. 312 (1974); Palmore v. Sidoti, 411 U.S. 389 (1973); Brown v. Board of Education, 347 U.S. 483 (1954).
117. Cleburne v. Cleburne Living Center, 473 U.S. 432, 439 (1985).
118. Cleburne, 473 U.S. at 439.
119. Lindsley v. Natural Carbonic Gas Co., 220 U.S. 61, 78-79 (1911); Royster Guano Co. v. Virginia, 253 U.S. 412 (1920).
120. Craig v. Boren, 429 U.S. 190 (1976).
121. Massachusetts Board of Retirement v. Murgia, 427 U.S. 307, 317 (1976) (Marshall, J., dissenting).
122. Murgia, 427 U.S. 307.
123. Prince v. Massachusetts, 321 U.S. 158 (1944).
124. Eisenstadt, 405 U.S. at 447, n.7.
125. 462 U.S. at 453 (O'Connor, J. dissenting).
126. See, e.g., Browning, 543 So. 2d 258; Georgia v. McAfee, 58 U.S.L.W. 2321 (Ga. 1989); Brophy, 497 N.E.2d at 626; Bouvia, 225 Cal. Rptr. at 304-305; Superintendent of Belchertown State School v. Saikewicz, 370 N.E.2d 417, 425 (Mass. 1977). For an early general discussion of these interests, see Byrn, Compulsory Lifesaving Treatment, supra, at 16-35.
127. Gray, 697 F. Supp. at 584.
128. U.S. Const. Art. IV, sec. 4.

129. U.S. Const. Art. I, sec. 8.

130. *Dent v. West Virginia*, 129 U.S. 114, 122 (1889); see also *Semler v. Oregon State Board of Dental Examiners*, 294 U.S. 608, 611 (1935) where the Supreme Court held that states may use their police power to "afford protection against ignorance, incapacity and imposition."

131. *In re Storar*, 438 N.Y.S.2d 266, 275 (N.Y. 1981).

132. *Cruzan*, 760 S.W.2d at 422.

133. Rhoden, *Litigating Life and Death*, 102 Harv. L. Rev. 375, 440 (1989). See also Ellman, *Cruzan v. Harmon and the Dangerous Claim*, supra, at 400.

134. Callahan, *On Feeding the Dying*, 13 Hastings Ctr. Rep. 5, 22 (Oct. 1983). Lynn and Childress assert that "providing nutrition and hydration...symbolizes, expresses or conveys the essence of care and compassion, medical nutrition and hydration...[but it] may not always provide net benefits to the patient." Lynn & Childress, *By No Extraordinary Means*, supra, at 20 (emphasis in original).

135. *Gardner*, 534 A.2d at 954.

136. *Quinlan*, 355 A.2d at 665.

137. Rubenfeld, *The Right of Privacy*, 102 Harv. L. Rev. 737, 795, n.214 (1989).

138. Rubenfeld, *The Right of Privacy*, supra, at 795.

139. *Brophy*, 497 N.E.2d at 645 (Lynch, J., dissenting in part).

140. Brophy, 497 N.E.2d at 642-43.
141. Bouvia, 225 Cal. Rptr. at 306.
142. Bouvia, 225 Cal. Rptr. at 305.
143. Bouvia, 225 Cal. Rptr. at 307, 308 (Compton, J., concurring).
144. 10 U.S.C. sec. 915; Art. 115, Uniform Code of Military Justice.
145. Army Reg. 40-3, Medical Services: Medical, Dental, and Veterinary Care (15 Feb. 1985) [hereinafter, AR 40-3].
146. AR 40-3 at para 2-10. See also Army Reg. 600-20, Command Policy and Procedures (30 Mar 1988) [hereinafter, AR 600-20], para 5-4b(2).
147. AR 600-20, supra, at para 5-4a.
148. See, e.g., Application of President & Directors of Georgetown College, Inc., 331 F.2d 1000, cert. denied, 377 U.S. 978 (1964); Jehovah's Witnesses v. King County Hosp., 278 F. Supp. 488 (W.D. Wash. 1967), aff'd 390 U.S. 598 (1968); In re Ivey II, 319 So. 2d 53 (Fla. Dist. Ct. App. 1975); Custody of a Minor, 379 N.E.2d 1053, 1063 (Mass. 1978) (ordering chemotherapy for child with leukemia, despite parents' preference for laetrile); In re Vasko, 263 N.Y.S. 552, 555 (1933) (ordering eye-removal for a child whose cancer otherwise would result in death). See also Powell v. Columbian Presbyterian Medical Center, 267 N.Y.S.2d 450, 451 (1965) where a court ordered a transfusion after the patient's husband and children objected to her refusal, which was based on a refusal to sign the authorization, not to the transfusion itself. For more

cases supporting this principle see Quinlan, 355 A.2d at 660.

149. See generally Briefs Amici Curiae in support of petitioners by AMA and AAN, Cruzan v. Harmon (1989); Wanzer, et. al., The Physician and the Hopelessly Ill Patient: A Second Look, 320 New Eng. J. Med. 844 (1989). But see 54 Fed. Reg. 42,722 (1989) (to be codified at 45 C.F.R. sec. 60) for recently promulgated regulations by the U.S. Department of Health and Human Services creating a National Practitioner Data Bank for Adverse Information of Physicians and Other Health Care Practitioners. This Bank will keep track of malpractice awards and incidents of misconduct by physicians, dentists and other health care professionals, in an effort to keep them from travelling between jurisdictions with no record of prior misconduct. The U.S. Secretary of Health and Human Services is creating the bank in compliance with the Health Quality Improvement Act of 1986, Tit. IV, P.L. 99-660, as amended. According to the Federal Register, "the Act does not require the application of these provisions to federal health care entities, physicians, dentists and other health care providers. However, the intent of the law appears clear that coverage be as broad as possible, and hence the Secretary has entered into memoranda of agreement with the Department of Defense" and other federal agencies. 54 Fed. Reg. at 42,722.

150. See, e.g., Rhoden, Litigating Life and Death, supra, at 426, 432, 444-45; Culver, Is Life Ever a Failure?, 19 Hastings Ctr. Rep., 38 (July/August 1989).

151. Collins, To Die or Not to Die, N.Y. Times, Apr. 4, 1984 at A27, col. 1. [Collins was president of the Society for the Right to Die.]

152. Morning Edition, National Public Radio, Oct. 17, 1989. See also Randal, The Removal of Mr. Herbert's Feeding Tube, 14 Hastings

Ctr. Rep. 13, 14 (Oct. 1983), which reports that a nurse was reprimanded for restarting a sick man's respirator and working to keep him alive. Two days after he revived on his own, doctors ordered that food and water be withheld; they were tried for murder and acquitted.

153. Koop, Life and Death and the Handicapped Newborn, 5 Issues in Law and Medicine, 101, 109 (Summer 1989).

154. Morning Edition, National Public Radio, Jan. 11, 1990, discussing the facts behind Browning, 543 So. 2d 258.

155. See, infra, text accompanying n.n.364-68.

156. See, e.g., Arizona: Rasmussen, 741 P.2d 674; California: Drabick, 245 Cal. Rptr 840; Connecticut: McConnell, 553 A.2d 596; Delaware: Severns, 425 A.2d 156; District of Columbia: Tune, 602 F. Supp. 1452; Florida: John F. Kennedy Memorial, 452 So. 2d 921; Georgia: In re L.H.R., 321 S.E.2d 716; Hawaii: Wilcox v. Hawaii, Civ. No. 860116 (Hawaii Cir. Ct. 5th Cir. June 16, 1986); Illinois: In re Estate of Longeway, 58 U.S.L.W. 1081 (Ill. Sup. Ct. Nov. 13, 1989); Iowa: Morgan v. Olds, 417 N.W.2d 232 (Iowa Ct. App. 1987); Louisiana: In re P.V.W., 424 So. 2d 1015 (La. 1982); Maine: Gardner, 534 A.2d 947; Massachusetts: Brophy, 497 N.E.2d 626; Minnesota: Torres, 357 N.W.2d 332; New Jersey: Jobes, 529 A.2d 434; New York: Storar, 52 N.Y.S.2d 363 and O'Connor, 534 N.Y.S.2d; Ohio: Leach v. Akron General Medical Center, 426 N.E.2d 809 (Ct. Com. Pl. 1980); Rhode Island: Gray, 697 F. Supp. 580; Washington: Grant, 747 P.2d 445. Lower courts of several other states have ruled in favor of the right to die, but none of these decisions has been reported by one of the states' appellate courts.

157. Lojuk v. Quandt, 706 F.2d 1456, 1466 (7th Cir. 1983) cert. denied, 474 U.S. 1067 (1986).

158. Lojuk, 706 F.2d at 1466. See also Drabick, 245 Cal. Rptr. 840; Gardner, 534 A.2d 947; Rasmussen, 741 P.2d 674; Delio, 516 N.Y.S.2d 677; Brophy, 497 N.E.2d 332; Torres, 357 N.W.2d 332; Foody v. Manchester Memorial Hospital, 482 A.2d 713 (Conn. 1984).

159. Tribe, Constitutional Law, 1368, n.25 (1988).

160. Comment, The Refusal of Life-Sustaining Medical Treatment vs. the State's Interest in the Preservation of Life, 58 Wash. U.L.Q. 100 (1980).

161. Danforth, 428 U.S. 52 (1976).

162. Destro, Quality of Life Ethics, supra, at 71-72 (emphasis in original).

163. Conroy, 486 A.2d at 1229.

164. Ala. Code sections 22-8A-1 to -10 (1984); Cal. Health & Safety Code sections 7185 to 7195 (West Supp. 1989); Del. Code Ann. tit. 16, sections 2501 to 2509 (1983); D.C. Code Ann. sections 6-2421 to -2430 (Supp. 1988); Kan. Stat. Ann. sections 65-28,101 to -28,109 (1985); La. Rev. Stat. Ann. sections 40:1299.58.1 to -.10 (West Supp. 1989); Miss. Code Ann. sections 41-41-101 to -121 (Supp. 1988); Nev. Rev. Stat. sections 449.540 to -.690 (1986 & Supp. 1988); N.M. Stat. Ann. sections 24-7-1 to -11 (1986); N.C. Gen. Stat. sections 90-320 to -322 (1985); Tex. Rev. Civ. Stat. Ann. art. 4590h (Vernon Supp. 1989); Vt. Stat. Ann. tit. 18, sections 5251-5262 (1987); Va. Code sections 54.1-2981 to -2992 (1988); Wash. Rev. Code Ann. sections 70.122.010 to -.905 (Supp. 1989).

165. Alaska Stat. sec. 18.12.010(c) (1986); Ark. Stat. Ann. sec. 20-17-20(b) (Supp. 1987); Colo Rev. Stat. sec. 15-18-103(7) (1989); Idaho Code sec. 39-4504 (1985 and Supp. 1989); Ill. Ann. Stat. ch. 110 1/2, sec. 702(d) (Smith-Hurd Supp. 1989); Minn. Adult Health Care Decisions Act, S.28, Chapter 145B, sec. 145B.03 (1989); Mont. Code Ann. sec. 50-9-202(2) (1987); North Dakota Living Will Act, H. 1481, sec. 8(3), signed by Governor, Apr. 12, 1989; Or. Rev. Stat. sec. 97.050(3) (1984); Tenn. Code Ann. sec. 32-11-103(5) (1988).

166. Ariz. Rev. Stat. Ann. sec. 36-3201(4) (1986); Fla. Stat. Ann. sec. 765.03(3) (1986); Hawaii Rev. Stat. sec. 327D-2 (Supp. 1988); Ind. Code Ann. sec. 16-8-11-4 (Burns Supp. 1989); Iowa Code Ann. sec. 144A.2(5) (1989); Md. Health-General Code Ann. sec. 5-605 (Supp. 1988); N.H. Rev. Stat. Ann. sec. 137-H:2II (Supp. 1988); Okla. Stat. Ann. tit. 63, sec. 3102(4); S.C. Code Ann. sec. 44-77-20(2) (Law. Co-op Supp. 1988); Utah Code Ann. sec. 75-2-1103(6) (Supp. 1988); W.Va. Code sec. 16-30-2(3) (1985); Wyo. Stat. sec. 33-22-101(iii) (1988). Oklahoma addresses tube feeding separately at 63 Pub. Health & Safety sec. 3080 (West. 1987).

167. Conn. Gen. Stat. sec. 19a-570(1) (Supp. 1989); Ga. Code Ann. sections 31-32-2(5) (1985 & Supp. 1989); Me. Rev. Stat. Ann. tit. 22, sec. 2921(4) (Supp. 1988); Mo. Ann. Stat. sec. 459.010(3) (Vernon Supp. 1989); Wisc. Stat. Ann. sec. 154.01(5) (West 1989). Note that the Cruzan case was not affected by Missouri's statute, which was signed into law well after the litigation involving Nancy Cruzan began. More recently, some Missouri legislators have introduced a bill that would permit withdrawal of food and water from patients who have been PVS for at least 36 months when three physicians certify that the condition is irrevocable and that the withdrawal will not, of itself, cause the patient's death. Wash. Post, Mar. 17, 1990, at A-29, col. 1.

168. See, e.g., Rhode Island, whose statute sets out a form on which to make such a declaration. R.I. Gen. Laws secs. 23-4.10-1 to 23-4.10-2 (Supp. 1988).

169. See, e.g., Ark. Stat. Ann. sec 20-17-202 (1987), which sets the following order: parent of minor, spouse, child over 18, majority vote of children over 18 (it does not address a tie vote), either parent, then "nearest living relative."

170. See, e.g., Is a Living Will the Way to Go?, U.S. News & World Report, Aug. 24, 1987, at 65, in which the magazine told its readers that "[a] living will can protect you and your family from the indignity, heartbreak and financial devastation that your protracted death may mean." See also The Living Will, Aide Magazine, Dec. 1988, at 26, in which the USAA insurance company advises policy holders with an "unwillingness to be subjected to life-prolonging medical measures" that a living will "relieves others of the legal and emotional burden of making decisions for you" and that "[r]efusing life-support measures is not considered suicide."

171. See Estate Planning Note, The Army Lawyer, Dec. 1989, 42-44, for advice to judge advocates on how to serve clients who want living wills.

172. Grant, 747 P.2d 445 (Wash. 1987); Gardner, 534 A.2d 947 (Me. 1987). An unreported Georgia decision also limited the strict language of Georgia's living will statute. In re Jane Doe, No. D56730 (Super. Ct. Fulton County July 13, 1988).

173. See Gelfand, Living Will Statutes: The First Decade, 1987 Wisc. L.Rev. 737, 771-72; Miller, Problems in Hospital Law 351 (1986).

174. Cruzan, 760 S.W.2d at 432.
175. Cruzan, 760 S.W.2d at 424.
176. Brophy, 497 N.E.2d at 632, n.22.
177. Gardner, 534 A.2d at 953.
178. Gardner, 534 A.2d at 953.
179. Longeway, 58 U.S.L.W. 1081.
180. Hartke v. McKelway, 707 F.2d 1544, 1548-49 (D.C.Cir.), cert. denied, 464 U.S. 983 (1983); Lambert v. Park, 597 F.2d 236, 237, n.1 (10th Cir. 1979).
181. Conroy, 486 A.2d at 1231.
182. Meyers, Medico-Legal Implications of Death and Dying 277-79 (1981).
183. U.S. News & World Report, supra, at 65.
184. AMA Statement, supra, at para I.D.
185. Id. See also President's Commission, supra, at 181-82: "Pain and suffering are absent, as are joy, satisfaction and pleasure."
186. Telephone interview with the author, Sept. 21, 1989.
187. Quinlan, 355 A.2d at 657.
188. Destro, Quality of Life Ethics, supra, at 177.

189. AMA Statement, supra, at para II.D.

190. President's Commission, supra, at 181.

191. Matter of Beth Israel Medical Center, 519 N.Y.S.2d 511, 517 (Supp.1987). Many courts employ similar language, dating back to the Quinlan court, which said Karen was "probably irreversibly doomed to no more than a biologically vegetative remnant of life." Quinlan, 335 A.2d at 662.

192. Buchanan, The Limits of Proxy Decisionmaking for Incompetents, 29 UCLA L. Rev. 386, 402 (1981).

193. Id.

194. Rhoden, Litigating Life and Death, supra, at 400.

195. Destro, Quality of Life Ethics, supra, at 124, n.241.

196. Council on Ethical and Judicial Affairs, American Medical Association, Current Opinion, ix (1989).

197. AMA Statement, supra, at sec. II.

198. Brophy, 497 N.E.2d at 635. Accord Bouvia, 225 Cal. Rptr. at 306-07.

199. AAN Amicus Brief, supra, at 14.

200. Peter, 529 A.2d at 426.

201. Peter, 529 A.2d at 426.

202. AAN Amicus Brief, supra, at 23 (emphasis in original).

203. Destro, Quality of Life Ethics, supra, at 128, n.250 (citation omitted). Contra Gleitman v. Cosgrove, 227 A.2d 689 (N.J. 1967), rejecting the concept of "wrongful birth" suits.

204. Brophy, 497 N.E.2d at 636.

205. Brief Amicus Curiae in support of petitioners at 8, Cruzan v. Harmon, National Academy of Elder Law Attorneys (1989).

206. Brophy, 497 N.E.2d at 641, n.2.

207. Cranford, The Persistent Vegetative State: The Medical Reality, supra, at 27.

208. AMA Amicus Brief, supra, at 24. See also Koop, Life and Death and the Handicapped Newborn, supra, at 104, quoting two Yale physicians who discussed why they withheld food and water from handicapped newborns: "[P]arents and siblings' rights to relief to seemingly crushing burdens were important considerations in our decision."

209. Brief Amicus Curiae in support of petitioners at 6, Cruzan v. Harmon, Society for the Right to Die, (1989).

210. President's Commission, supra, at 192-93, 183. See also Livingston, Families Who Care, 291 Brit. Med. J. 919 (1979).

211. Conroy, 457 A.2d at 1234.

212. Pope Pius XII, Prolongation of Life: Allocution to an International Congress of Anesthesiologists, The Pope Speaks, 4: 393-398 (November 1957).

213. Id.

214. The Sacred Congregation for the Doctrine of the Faith, Declaration on Euthanasia (May 5, 1980).

215. See Standards and Guidelines for Cardiopulmonary Resuscitation (CPR) and Emergency Cardiac Care (ECC), 255 J.A.M.A. 2905, 2905 (1986).

216. "[T]he ordinary/extraordinary distinction, frequently invoked a decade ago and cited by the court in the Quinlan case is imbued with so many diverse and incompatible interpretations as to be unhelpful in guiding decisions for the care of the incompetent." Emanuel, A Communal Vision of Care for Incompetent Patients, 17 Hastings Ctr. Rep. 5, 15 (Oct./Nov. 1987).

217. Brophy, 497 N.E.2d at 637. Accord Conroy, 486 A.2d at 1234-35.

218. Task Force on Ethical Issues in Human Medicine, Office of Research and Analysis, The American Lutheran Church, para A5 (July 1977).

219. Quinlan, 355 A.2d at 658, 668.

220. Rhoden, Litigating Life and Death, supra, at 377.

221. Destro, The Emerging "Right" to a Good Life, This World, 73 at 77, 78 (Spring 1989) [hereinafter, The "Right to a Good Life"].

222. Rhoden, Litigating Life and Death, supra, at 397.

223. Rhoden, Litigating Life and Death, supra, at 437.

224. Substituted Judgement: Best Interests in Disguise, 13 Hastings Ctr. Rep. 8, 10 (June, 1983).

225. Id. at 8, 9.

226. Rhoden, Litigating Life and Death, supra, at 443-44.

227. Rhoden, Litigating Life and Death, supra, at 398, n.99.

228. Beth Israel, 519 N.Y.S.2d 511 at 517.

229. President's Commission, supra, at 192-93, 83.

230. President's Commission, supra, at 136.

231. Destro, Quality of Life Ethics, supra, at 112.

232. Destro, The "Right" to a Good Life, supra, at 78 (emphasis in original).

233. Conroy, 486 A.2d at 1246 (Handler, J., concurring).

234. Burt, Taking Care of Strangers, supra, at 149-53 (1979); see also Rhoden, Litigating Life and Death, supra, at 387.

235. Conroy, 486 A.2d at 1232-33.

236. Brophy, 497 N.E.2d at 643 (Lynch, J., dissenting in part).

237. Jobes, 529 A.2d at 458 (Handler, J., concurring).

238. Destro, The "Right" to a Good Life, supra, at 78.

239. Emanuel, A Communal Vision of Care for Incompetent Patients, supra, at 15.

240. Rhoden, Litigating Life and Death, supra, at 420.

241. Rhoden, Litigating Life and Death, supra, at 379, 420.

242. See, supra, text accompanying n.n.55-60.

243. Michael H., 109 S.Ct. at 2342, 2343, quoting Moore, 431 U.S. at 503.

244. 468 U.S. 609, 618-20 (1984).

245. Rhoden, Litigating Life and Death, supra, at 438-39.

246. Smith v. Organization of Foster Families for Equality and Reform, 431 U.S. 816, 844 (1977).

247. Demos, The American Family in Past Time, 43 Am. Scholar 422, 424 (1974).

248. Family members traditionally make such decisions for minors and incompetents, and many states' informed consent statutes reflect this. See, e.g., Ark. Code Ann. sec 20-9-602; La. Rev. Stat. Ann. sec. 40:1299.53. "[A] constitutional right of families to decide these issues has never been recognized." Rhoden, Litigating Life and Death, supra, at 384. See Destro, Quality of Life Ethics, supra, at 98, n.114 for a discussion of court intervention into parents' choices for their children, including a summary of factors courts traditionally employ in deciding whether to order treatment despite parental objections.

249. McConnell, 553 A.2d at 604.

250. Jobes, 529 A.2d at 445, quoting Newman, Treatment Refusals for the Critically Ill: Proposed Rules for the Family, the Physician and the State, III N.Y. L. Sch. Hum. Rts. Ann. 45-46 (1985).

251. Jobes, 529 A.2d at 445. For further criticism of continuing to feed patients for symbolic reasons, see, supra, text accompanying n.n.130-32.

252. Ellman, Cruzan v. Harmon and the Dangerous Claim, supra, at 401.

253. McCormick on Evidence, sections 336-41 (1984).

254. Addington v. Texas, 441 U.S. 418, 433 (1979). Accord Jobes, 529 A.2d at 446-447, n.11.

255. Santosky, 445 U.S. 745 (1982).

256. O'Connor, 534 N.Y.S.2d at 886, 891-93.

257. O'Connor, 534 N.Y.S.2d at 892.

258. O'Connor, 534 N.Y.S.2d at 892.

259. O'Connor, 534 N.Y.S.2d at 893. The court continued: "The aged and inform would be at grave risk if the law...treated the expressions of such sentiments as a calm and deliberate resolution not to be fed."

260. O'Connor, 534 N.Y.S.2d at 904 (Simons, J., dissenting).

261. O'Connor, 534 N.Y.S.2d at 895, 896 (Hancock, J., concurring).

262. See, e.g., Storar, 420 N.E.2d 65; Gardner, 534 A.2d 947, 952; Longeway, 58 U.S.L.W. 1081; Conroy, 486 A.2d 1209.

263. N.Y. Times, Nov. 13, 1988, at A8, col. 1.

264. Rhoden, Litigating Life and Death, supra, at 376, 392.

265. Id. at 376, 386, 391, n.74.

266. Id. at 390.

267. President's Commission, supra, at 136.

268. AR 40-3 supra, and Letter, HQDA, DASG-PSQ, 30 Aug. 1985, subject: Withdrawal of Life-Sustaining Treatment [hereinafter, HQDA Letter].

269. Letter, HQAF-SGPC, 21 Jul 1982, subject: Management of Terminally Ill Patients; Letter, HQAF, AFSG-SGP, 14 Apr 1980, subject: Management of Terminally Ill Patients; Letter, HQAF-JACC, 5 Mar 1980, subject: Management of Terminally Ill Patients.

270. HQDA Letter, para 3b.

271. HQDA Letter, para 3c.

272. HQDA Letter, para 2a, authorizes termination of life-sustaining procedures including "lavage feeding." Apparently the drafters meant gavage feeding, another term for artificial nutrition and hydration delivered via feeding tubes. See Woodruff, Letting Life Run Its Course: Do-Not Resuscitate Orders and Withdrawal of Life-Sustaining Treatment, The Army Lawyer, April 1989, 7, 12, n.67 [hereinafter, Woodruff, Letting Life Run Its Course].

273. HQDA Letter, para 4b.

274. United States v. Rutherford, 442 U.S. 544, 556 (1979).

275. Rutherford, 442 U.S. at 556, n.14.

276. HQDA Letter, para 3a (emphasis added).

277. Id.

278. Id.

279. Id.

280. AR 40-3, para 2g.

281. HQDA Letter, para 3d.

282. HQDA Letter, para 2i.

283. Id. The regulation is more specific in the composition of ethics panels that weigh do-not-resuscitate orders. It requires that such panels include at least two physicians, a nurse, a chaplain and a representative of the local staff judge advocate. AR 40-3, para 19-2g.

284. President's Commission, supra, at 443-449. For a further critique of the committees see Randal, Are Ethics Committees Alive and Well?, 13 Hastings Ctr. Rep. 10 (Dec. 1983).

285. Woodruff, Letting Life Run Its Course, supra, at 12, n.69 (citation omitted).

286. DeDonato, The Ethics of Dying: Difficult Decisions in Army Medicine, Mil. Chaplains' Rev., Spring 1989, 59, 74.

287. Webster v. Reproductive Health Services, 109 S.Ct. 3040, 3051-52 (1989).

288. Webster, 109 S.Ct. at 3052.

289. Webster, 109 S.Ct. at 3058.

290. Webster, 109 S.Ct. at 3056-57. Ely presaged this problem in 1973 when he called the Roe opinion "a sort of guidebook, addressing questions not before the Court and drawing lines with an apparent precision one generally associates with a commissioner's regulations." Ely, The Wages of Crying Wolf, supra, at 922 (footnote omitted).

291. Webster, 109 S.Ct. at 3057 (citations omitted).

292. Rhoden, Litigating Life and Death, supra, at 434 (citations omitted).

293. Webster, 109 S.Ct. at 3073 (Blackmun, J., dissenting). Rubenfeld argues that the Court "has always gone beyond the literal constitutional text...and no doubt will continue to do so" and that it should not be restrained "by the meaninglessness of the idea of a 'literal' text." Rubenfeld, The Right of Privacy, supra, at 738, 742-44.

294. Rubenfeld, The Right of Privacy, supra, at 739.

295. Ely, The Wages of Crying Wolf, supra, at 923, 926.

296. Id. at 927-28.

297. Ely, The Wages of Crying Wolf, supra, at 928, 928, n.60. But see, Rubenfeld, The Right of Privacy, supra, at 737 for the argument that "[p]rivacy doctrine supposes...that the judiciary is an appropriate body to determine whether a law transgresses these implicit limits."

298. Bork, The Tempting of America 95 (1989).

299. Bork, The Tempting of America, supra, at 97, 99, 100.

300. Ellman writes that the Missouri Supreme Court's "blunt assessment" that it was being asked to allow Nancy Cruzan to be starved was correct, but that the "court's real mistake was finding an important moral and legal difference between the discontinuance of technologically supplied nutrition and other forms of medical treatment. While Ellman supports the distinction, he said the fact that most courts do not makes the decision difficult for the Supreme Court. He said that because "[t]he Missouri Supreme Court effectively treats the gastronomy tube like the dinner tray, while most other authorities treat it like a respirator," the Supreme Court will have to choose between accepting the "ordered judgment" of most state courts or rejecting such a method of constitutional analysis and select Missouri's definition. Ellman, Cruzan v. Harmon and the Dangerous Claim, supra, at 391-92.

301. Bowers, 478 U.S. at 194-95.

302. Rubenfeld, The Right of Privacy, supra, at 747.

303. Bowers, 478 U.S. at 194.

304. Destro, Quality of Life Ethics, supra, at 85, n.68.

305. 483 U.S. 435, 448-450 (1987).

306. Webster, 109 S.Ct. at 3056 (citations omitted). See also Justice O'Connor's statement that "there will be time enough to reexamine Roe" [Webster, 109 S.Ct. at 3061 (O'Connor, J., concurring in part)]; and Justice Scalia's criticism of the Court for not explicitly overturning Roe [Webster, 109 S.Ct. at 3064-67 (Scalia, J., concurring)].

307. Rubenfeld, The Right of Privacy, supra, at 739.

308. Webster, 109 S.Ct. at 3072, (Blackmun, J., dissenting).

309. Webster, 109 S.Ct. at 3058.

310. Webster, 109 S.Ct. at 3065 (Scalia, J., concurring in part).

311. Jobs, 529 A.2d at 451.

312. Rutherford, 442 U.S. at 555 (citation omitted).

313. Conroy, 486 A.2d at 1220-21. Accord Hamlin, 689 P.2d at 1378-79; Satz v. Perlmutter, 370 So. 2d 359, 360 (Fla. 1980).

314. Cleburne, 105 S.Ct. at 3258 (footnote omitted).

315. Ferguson v. Skrupa, 372 U.S. 726, 729-30 (footnote omitted) (1963).

316. Destro, Quality of Life Ethics, supra, at 124.

317. Destro, Quality of Life Ethics, supra, at 127.

318. Ellman, Cruzan v. Harmon and the Dangerous Claim, supra, at 399, 401.

319. Destro, Quality of Life Ethics, supra, at 72.

320. "Should the law itself adopt the view that the legal protection of an individual's life is to be determined by its quality rather than by its human nature, it would be an understatement to assert that the impact will be profound." Destro, The Right to a "Good" Life, supra, at 73 (emphasis in original).

321. Koop, Life and Death and the Handicapped Newborn, supra, at 101.

322. Spence, Do Not Go Slowly Into That Dark Night: Mercy Killing in Holland, 84 Am. J. Med. 139 (1985). The Dutch, of course, are well-known for the widespread, legal practice of euthanasia in their crowded country, the most densely populated in Europe. Most estimates are that 5,000 to 10,000 Dutch patients per year die as a result of "mercy killing." However, the practice remains controversial, even in the Netherlands. See deWachter, Active Euthanasia in the Netherlands, 262 J.A.M.A. 3316 (Dec. 15, 1989); and Fenigsen, A Case Against Dutch Euthanasia, 19 Hastings Ctr. Rep. 22 (Jan./Feb. 1989).

323. Editorial, A New Ethic for Medicine and Society, Cal. Med. at 68 (Sept. 1970).

324. In a new book, Daniel Callahan discusses the rationing of medical care and its implications in deciding who should be "allowed to die." See Callahan, What Kind of Life: The Limitations of Medical Progress, passim (1990). Several other recent books provide general discussions and guidance regarding the impact of

finite medical resources on personal medical decisions. See, e.g., Rivlin & Weiner, Caring for the Disabled Elderly: Who Will Pay? (1989); Myers, How to Keep Control of Your Life After 60: A Guide for Your Legal, Medical and Financial Well Being (1989) [includes recommendations for living wills]; and Shelley, When Your Parents Grow Old: Information and Resources to Help the Adult Son or Daughter Cope With the Problems of Aging Parents (1989).

325. DeDonato, The Ethics of Dying, supra, at 72 (footnote omitted).

326. AR 40-3, para 13-2b.

327. Koop, Life and Death and the Handicapped Newborn, supra, at 108.

328. Commentary, Sanctity of Life or Quality of Life?, 72 Pediatrics 128 (July 1983).

329. Roe, 410 U.S. at 163.

330. Ely, The Wages of Crying Wolf, supra, at 932, n.81.

331. Brophy, Guardian v. New England Sinai Hosp., No. 85E009-G1, slip. op. at 9, quoted in Destro, Quality of Life Ethics, supra, at 122, n.231.

332. Destro, Quality of Life Ethics, supra, at 120.

333. Destro, Quality of Life Ethics, supra, at 125, n.243.

334. President's Commission, supra, at 183.

335. See, e.g., Humphrey, Let Me Die Before I Wake (1981); Kohl, Beneficent Euthanasia (1975). M. Pabst Battin argues that patients who want to die now must be satisfied with the "least worst death" of legally-sanctioned withdrawal of food and water, because the law has not advanced to permitting more humane alternatives, especially lethal injection. Battin, The Least Worst Death, 13 Hastings Ctr. Rep. 13, 17 (April 1983).

336. Destro, Quality of Life Ethics, supra, at 111.

337. Buck v. Bell, 274 U.S. 200, 203 (1927).

338. Grant, 747 P.2d at 458, 459 (Anderson, J., concurring in part and dissenting in part).

339. N.Y. Times, March 29, 1984 at A16, col. 5. According to the Times, Gov. Lamm emphasized that "the costs of treatment that allows the terminally ill to live longer was ruining the nation's health." He said the elderly should "[l]et the other society, our kids, build a reasonable life" by not postponing their deaths. Id.

340. Wikler, Not Dead, Not Dying? Ethical Categories and Persistent Vegetative State, 18 Hastings Ctr. Rep. 41, 44 (Feb./March 1988).

341. Id. at 45. For a discussion of the concept of declaring those with only lower brain functions to be legally dead, see Smith, Legal Recognition of Neocortical Death, 11 Cornell L. Rev. 850, 850-88 (1986).

342. Callahan, Setting Limits in An Aging Society (1987). See also Veatch, Justice and the Economics of Terminal Illness, 18 Hastings Ctr. Rep. 34, 40 (Aug./Sept. 1988).

343. Shaw, Defining the Quality of Life, 7 Hastings Ctr. Rep. 11 (1977). Shaw reasserted the formula 11 years later in Shaw, QL Revisited, 18 Hastings Ctr. Rep. 10 (Apr./May 1988). There is no shortage of such equations. Another bioethicist suggests the following method for accomplishing the benefits/burdens balancing:

$$\begin{array}{rcccl} \text{strength of the duty} & & \text{chance} & & \text{quality} & & \text{length} \\ \text{of beneficence for} & = & \text{of} & \times & \text{of} & \times & \text{of} \\ \text{incompetent patients} & & \text{success} & & \text{life} & & \text{life} \end{array}$$

C O S T

Ezekial, A Communal Vision, supra, at 15-16 (citation omitted).

344. Koop, Life and Death and the Handicapped Newborn, supra, at 106.

345. Id.

346. Destro, The "Right" to a Good Life, supra, at 80.

347. The California Humane and Dignified Death Initiative, 19 Hastings Ctr. Rep., special supp. at 10 (Jan./Feb. 1989).

348. The Latest Word, Hastings Ctr. Rep. 45 (July/Aug. 1989).

349. Capron, Anencephalic Donors: Separating the Dead From the Dying, Hastings Ctr. Rep. 5, 6 (Feb. 1987).

350. Peabody, Emery & Ashwal, Experience with Anencephalic Infants as Proposed Organ Donors, 321 New Eng. J. Med.:6, 344-50 (Aug. 10, 1989).

351. Shewmon, Caution in the Definition and Diagnosis of Infant Brain Death, in Monagle & Thomasma, eds., Medical Ethics: A Guide for Health Professionals 38 (1986).

352. Capron, Anencephalic Donors, supra, at 6.

353. Capron, Anencephalic Donors, supra, at 8.

354. Annas, From Canada With Love: Anencephalic Newborns as Organ Donors?, Hastings Ctr. Rpt. 36, 38 (Dec. 1987).

355. The Latest Word, supra, at 45.

356. See, e.g., In re Phillip B, A Minor, no. 66103 (Super. Ct., Santa Clara County, Calif., Apr. 27, 1978), aff'd 156 Cal. Rptr. 48 (1979), cert. denied, 445 U.S. 949 (1980); In re Infant Doe, No. GU 8204-00 (Cir. Ct. Monroe County, Ind. Apr. 12, 1982), aff'd sub nom., State of Indiana on Relation of Infant Doe by Guardian, No. 482 S139 (Ind. S.Ct. May 27, 1982), No. 482 S140 (Ind. S.Ct. Apr. 26, 1983), cert. denied, 464 U.S. 961 (1983).

357. Willke & Andrusko, Personhood Redux, 18 Hastings Ctr. Rep. 30 at 32, 33 (Oct./Nov. 1988) (emphasis in original).

358. Gianelli, Pediatric Surgeon Back in the Spotlight with Controversial New Donor, Am. Med. News, Nov. 5, 1987 at 80 (emphasis in original).

359. AR 40-3, para 18-7.

360. The medical impact of the early hours of the Panama invasion is described in "The Wounds of War," The Wash. Post, Jan. 9, 1990 at Health, 12.

361. Estate Planning Note, supra, at 42-44.

362. The Wash. Post, Jan. 9, 1990, supra.

363. The court said Joseph Quinlan could assert Karen's right to privacy in his own right as her parent (Karen was an adult) and as her surrogate. Quinlan, 355 A.2d at 657.

364. It is Army policy to return "the greatest number of individuals to duty as quickly as possible." AR 40-3, para 17-3c. See also AR 40-3, para 17-2a.

365. See, e.g., Alaska Stat. sec. 18.12.090 which provides that a "declaration executed in another state or a territory or possession of the United States in compliance with the law of that jurisdiction is effective for purposes of this chapter." The other states with reciprocity provisions are Arkansas, Hawaii, Maine, Maryland and Montana. Except for Hawaii, none of the six states is the home for a major Army medical facility. For full statutory citations see, supra, n.n. 161-64.

366. The regulation would have to make explicit that physicians will comply with local law when attempts are made to withdraw food and water overseas. The current regulation on abortion provides guidance: "In all cases, abortions will be performed in accordance with laws of the host nation." AR 40-3, para 2-34c(3).

367. Army policy directs "[t]reatment...primarily toward those casualties who can be returned to duty most promptly." AR 40-3, para 17-2a. See also AR 40-3, para 17-3c.

368. AR 40-3, para 13-2b addresses treatment in other military hospitals. Chapter 15 addresses treatment in other federal facilities and chapter 16 addresses other facilities; both are silent on whose regulations will apply or the extent to which the Army expects to be able to direct the care of its soldiers in those hospitals.

369. AR 40-3, para 2-34(e) provides: "AMEDD [Army Medical Department] personnel do not have to perform or take part in surgical procedures authorized by this paragraph that violate their moral or religious principles. Moral or religious objections will be considered as lack of capability to provide this care."

370. Gray, 697 F. Supp. at 590, 591.

371. Jobes, 529 A.2d at 45.

372. Brophy, 497 N.E.2d at 638-39. Another justice said that requiring transfer of a patient "did not require hospitals or medical professionals to take measures contrary to their ethical views concerning their duty to their patients." Brophy, 497 N.E.2d at 643 (O'Connor, J., concurring).

373. Grant, 747 P.2d at 456, n.6.

374. Letters, 17 Hastings Ctr. Rep. 43 (Oct./Nov. 1987).

375. In the opening verse of a popular call-and-answer cadence call at the Airborne School at Fort Benning, GA, soldiers sing: "My girl's a vegetable/Lives in a hospital/I'd buy her anything/To keep her alive." A later verse: "The other day I played a joke/Pulled the plug and watched her choke/I'd buy her anything/To keep her alive."

376. Destro, Quality of Life Ethics, supra, at 83, n.51 (emphasis in original).

377. Wisc. Stat. Ann. sec. 154.01 (West Supp. 1989). See also Okla. Stat. Ann. 63 sec. 3102 (West. 1987), which declares that life-sustaining procedures that may be withdrawn via living wills "shall not include the administering of nourishment, hydration and

medication."

378. S.C. Code Ann. sec. 44-77-20(2) (Law. Co-op Supp. 1988).

379. S.C. Code Ann. sec. (44-77-50).

380. The military operates 167 medical centers. See Brief, Amicus Curiae at 1, in support of respondents, Cruzan v. Harmon (1989), The United States of America.

381. Mo. Rev. Stats. sections 188.210, 188.215 (1986) quoted in Webster, 109 S.Ct. at 3050.

382. 448 U.S. 297 (1980).

383. Okla. Stat. Ann. 63 sec. 3080.3 (West Supp. 1987).

384. Okla. Stat. Ann. 63 sec. 3080.4 (West Supp. 1987).

385. Id.

386. In Miranda v. Arizona, 384 U.S. 436 (1966) the Supreme Court required that law enforcement personnel read suspects in police custody their fifth amendment rights before asking them questions about suspected criminal activity.

387. See generally Bopp, Nutrition and Hydration, supra, at 33-36, 50, for a discussion of informed consent standards for denial of food and water.

388. See, e.g., Thornburg, 476 U.S. at 756, in which the Court found unconstitutional the requirements to disclose before an abortion, the physician's name, the gestational stage of the fetus, the medical risks associated with abortion and an offer of

materials for the mother to review that described the probable anatomical and physiological characteristics of the fetus.

389. Wisc. Stat. Ann. 154.01(8).

390. Mont. Code Ann. sec. 50-9-102(12).

391. Okla. Stat. Ann. 63 sec. 3080.4 (West Supp. 1987). The statute does not address the Gray requirement that the patient be transferred to a facility that would grant his wish, but that should not normally be a problem once the military adopts uniform standards.

392. Fleischman & Murray, Ethics Committees for Infants Doe?, 13 Hastings Ctr. Rep. 5,9 (Dec. 1983).

393. DeDonato, The Ethics of Dying, supra, at 74.

394. For example, a Dane argued that his country has had successful ethics committees on which "the native intelligence and common sense of the farmer, fisherman and housewife served as a useful antidote to professional eccentricities." In Europe, Hospital Ethics Committee Seek an Identity, 17 Hastings Ctr. Rep. 4 (Aug. 1987).

395. Quinlan, 355 A.2d at 669.

396. "[T]he doctors are partners and at the end of the year receive bonuses based upon the profitability of the operation. Steinbock, Removing Mr. Herbert's Feeding Tube, supra, at 16.

397. "[I]t is not implausible to suppose that [ethics committees] will be pressed into service as hand maidens to money-saving strategies of doctors and insurance companies." Willke and Andrusko, Personhood Redux, supra, at 12.

398. Koop, The Challenge of Definition, 19 Hastings Ctr. Rep. 2, 3 (Jan./Feb. 1989).

399. Destro, Quality of Life Ethics, supra, at 120.